

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

STATE OF MARYLAND DEPARTMENT OF HEALTH—BALTIMORE, 18

3103

Item 2 Film G227 4-2-58 et.
Item 9 Film G227 9/20/58 ggi

CERTIFICATE OF DEATH

Reg. Dist. No.

03078

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 29	
c. LENGTH OF STAY IN 1b 17yr. 4mo. 28dys		d. STREET ADDRESS St. Mary's Orphanage	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Baker Last Baker		4. DATE OF DEATH Month March Day 20 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid	
10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. unk		17. INFORMANT Springfield State Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychosis with convulsive disorder- epileptic deterioration			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. <input type="checkbox"/> p. m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 7, 1955 , to March 20, 1958 , that I last saw the deceased alive on March 20, 1958 , and that death occurred at 7:20 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Agustin del Campo		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		DATE SIGNED 3/21/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-58	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight		ADDRESS Sykesville, Md.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE W. H. H. H.	

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. HARRIS		JAN 15 1938	
AGE		SEX	
65		M	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
Carpenter		Heart Disease	
PLACE OF DEATH		MANNER OF DEATH	
Home		Natural	
CITY		COUNTY	
BALTIMORE		BALTIMORE	
STATE		COUNTRY	
MD		USA	
DATE OF BIRTH		DATE OF DEATH	
JAN 1 1873		JAN 15 1938	
PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE		BALTIMORE	
CITY		COUNTY	
BALTIMORE		BALTIMORE	
STATE		COUNTRY	
MD		USA	
DATE OF BIRTH		DATE OF DEATH	
JAN 1 1873		JAN 15 1938	
PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE		BALTIMORE	
CITY		COUNTY	
BALTIMORE		BALTIMORE	
STATE		COUNTRY	
MD		USA	

RECEIVED
MAR 27 1938
BUREAU V. E.

3104

CERTIFICATE OF DEATH

Reg. Dist. No. 03079

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3908 Baltimore Street			
3. NAME OF DECEASED (Type or print) First Middle Last Evalena Snyder Brookover BARKER				4. DATE OF DEATH Month Day Year March 18, 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 8, 1876	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Martin Brookover				14. MOTHER'S MAIDEN NAME Anna Snyder			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -				16. SOCIAL SECURITY NO. -			
17. INFORMANT Springfield Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular paroxysmal tachycardia 420.0 DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) - DUE TO (c) - C.B.S. associated with arteriosclerotic heart disease.							INTERVAL BETWEEN ONSET AND DEATH Days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from March 3, 1958 to March 18, 1958 , that I last saw the deceased alive on March 17, 1958 , and that death occurred at 6:35A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3/18/58 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/20/58		22c. NAME OF CEMETERY OR CREMATORY COLESVILLE CEMETERY		22d. LOCATION (City, town, or county) (State) MONTGOMERY COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Walter E. Pamphrey				ADDRESS Silver Spring, Md.		DATE MAR 24 '58	
24b. REGISTRAR'S SIGNATURE Dee Smith							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03080

3096

Item 2 FilmG226 3-13-58 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it as a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BLADDER</u> <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>70 CHURCH ST.</u>		e. STREET ADDRESS <u>70 S. Church Street</u>	
3. NAME OF DECEASED (Type or print) <u>ABBIE</u> First <u>IT</u> Middle <u>BARTER</u> Last		4. DATE OF DEATH Month <u>MAR</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-1900</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESWOMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MAINE</u>	
11. BIRTHPLACE (State or foreign country) <u>MAINE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Simon S. Knowlton</u>		14. MOTHER'S MAIDEN NAME <u>Emma Monteth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>005-05-1024</u>	
17. INFORMANT <u>Dorothy Smith</u> Address <u>70 Church St. Westminster Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONIA</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>JAMES T. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>3/5/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-8-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Knowlton Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Stonington Maine</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David A. Bankard</u>		24a. REC'D BY REGISTRAR <u>Westminster Md.</u>	
24b. REGISTRAR'S SIGNATURE <u>Westminster Md.</u>		DATE <u>MAR 10 '58</u>	

FOR STATE
HEALTH DEPT.

BUREAU V. S.

MAR 10 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3105

CERTIFICATE OF DEATH

Reg. Dist. No.

03081

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>UNION BRIDGE</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>RURAL Bucher John Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>EARL</u> Middle <u>GARFIELD</u> Last <u>BEARD</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>23</u> Year <u>1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 17 - 1880</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>17</u> Hours <u>19</u> Min.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER - RETIRED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TENANT</u>			
13. FATHER'S NAME <u>John Beard</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET BOSTIAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>HERMAN C. BEARD</u> Address <u>Union Bridge MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. ft. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 16 1958</u> to <u>Mar 23 1958</u> , that I last saw the deceased alive on <u>Mar 22 1958</u> , and that death occurred at <u>8:45 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. H. Legg</u>				ADDRESS (Street, city or town) state <u>Union Bridge</u>			
PHYSICIAN'S NAME (Type) <u>T. H. Legg M.D.</u>				DATE SIGNED <u>3-24-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LINGANORO Con.</u>		22d. LOCATION (City, town, or county) (State) <u>Unionville MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Hartshorn</u>				ADDRESS <u>Union Bridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 27 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		PLACE OF DEATH [Faint text]	
CAUSE OF DEATH [Faint text]		MANNER OF DEATH [Faint text]		PLACE OF BIRTH [Faint text]	
OCCUPATION [Faint text]		EDUCATION [Faint text]		COLOR [Faint text]	
MARITAL STATUS [Faint text]		RELIGION [Faint text]		US BORN [Faint text]	
PREVIOUS MARRIAGES [Faint text]		PREVIOUS DEATHS [Faint text]		PREVIOUS INMATE [Faint text]	
PREVIOUS ARRESTS [Faint text]		PREVIOUS CONFINEMENT [Faint text]		PREVIOUS DEPORTATION [Faint text]	
PREVIOUS SENTENCES [Faint text]		PREVIOUS PROBATION [Faint text]		PREVIOUS PAROLE [Faint text]	
PREVIOUS MENTAL ILLNESS [Faint text]		PREVIOUS PHYSICAL ILLNESS [Faint text]		PREVIOUS DRUG ABUSE [Faint text]	
PREVIOUS ALCOHOL ABUSE [Faint text]		PREVIOUS TOBACCO USE [Faint text]		PREVIOUS OTHER SUBSTANCE USE [Faint text]	
PREVIOUS OTHER ADDICTIONS [Faint text]		PREVIOUS OTHER HABITS [Faint text]		PREVIOUS OTHER FACTORS [Faint text]	
PREVIOUS OTHER INFORMATION [Faint text]		PREVIOUS OTHER COMMENTS [Faint text]		PREVIOUS OTHER NOTES [Faint text]	

BUREAU V. 1

MAR 27 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3106

CERTIFICATE OF DEATH

03082

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> c. LENGTH OF STAY IN 1b <u>YEARS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER ADAM BOWER</u>				4. DATE OF DEATH Month Day Year <u>MARCH 6 19 58</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/29/1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ANTIQUE - DEALER</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>JOHN S. BOWER</u>		14. MOTHER'S MAIDEN NAME <u>LUCINDA REAVER</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>218-32-4079</u>		17. INFORMANT <u>BERTHA R. BOWER, NEW WINDSOR MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>11/29/56</u> 19 <u>56</u> , to <u>3/6/58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/1/58</u> , 19 <u>58</u> , and that death occurred at <u>5 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>ME Robertson</u> M.D.				ADDRESS (Street, city or town, state) <u>New Windsor, Md</u>			
DATE SIGNED <u>3/6/58</u>				PHYSICIAN'S NAME (Type) <u>M. F. ROBERTSON</u> <u>NEW WINDSOR MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM. CARROLL COUNTY MD.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD Harkless New Windsor, Md.</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 10 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3097

CERTIFICATE OF DEATH

03083

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster				c. LENGTH OF STAY IN 1b 18 Years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 193 Pennsylvania Avenue				d. STREET ADDRESS 193 Pennsylvania Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Denton Middle Jeremiah Last Bowersox				4. DATE OF DEATH Month March Day 10 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/25/1884	9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat Cutter—Retired		10b. KIND OF BUSINESS OR INDUSTRY Super Market		11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jeremiah Bowersox				14. MOTHER'S MAIDEN NAME Amelia Barbara Stengel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-7547		17. INFORMANT Paul E. Bowersox Address Westminster, Md. Paul E. Bowersox, 331 Margaret Ave., M.R.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 4 hours 8 years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. n. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 3/9 , 19 58 , to 3/10 , 19 58 that I last saw the deceased alive on 3/10 , 19 58 , and that death occurred at 6 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Phuenter Bare M.D.				ADDRESS (Street, city or town, state) Westminster, Md. DATE SIGNED 3/10/58			
PHYSICIAN'S NAME (Type) S. LUTHER BARE							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/58		22c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery		22d. LOCATION (City, town, or county) (State) Silver Run, Carroll Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little				ADDRESS Littlestown, Pa.		24a. REG'D BY REGISTRAR MAR 11 58	
				24b. REGISTRAR'S SIGNATURE W. Beach			

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3107

CERTIFICATE OF DEATH

Reg. Dist. No. 03084

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admision) o. STATE <u>Maryland</u> b. COUNTY <u>City</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 5, Md.</u> <u>3V01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>915 H⁺gnet Way</u>			
3. NAME OF DECEASED (Type or print) First <u>Stella</u> Middle <u>Maude</u> Last <u>Brown</u>				4. DATE OF DEATH Month <u>3</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>Fem</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-21-93</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>C. Jess Watkins</u>				14. MOTHER'S MAIDEN NAME <u>Mary Snyder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unkn</u>		17. INFORMANT <u>Springfield Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260.8 C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction</u> <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-13-</u> , 19 <u>55</u> , to <u>3-22-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3-22-</u> , 19 <u>58</u> , and that death occurred at <u>2:0 P. M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edmund Lusthaus</u> M.D.				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>3-22-58</u>			
PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus M.D.</u>				<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/26/58</u>		<u>Glenhaven Cem.</u>		<u>Glenburnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Vickner & Sons - Balt 17th</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. J. Vickner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3108

CERTIFICATE OF DEATH

Reg. Dist. No. 03085

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 31			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Estelle Middle M. Last Burks				4. DATE OF DEATH Month 3 Day 31 Year 1958			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 10, 1901	9. AGE (In years lost birthday) 56 yrs.	IF UNDER 1 YEAR Months 56 Days 31 Hours 1958	IF UNDER 24 HRS. Months 56 Days 31 Hours 1958	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Ridgeway, S. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James McKay				14. MOTHER'S MAIDEN NAME Amanda Commander			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address Edward McKay Miller - 309 Avondale Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive hypertensive arteriosclerotic Cardiovascular disease. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Renal insufficiency & Diabetes Mellitus DUE TO (c) Pulmonary Tuberculosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 002x							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 28, 1958 , to March 31, 1958 , that I last saw the deceased alive on March 31, 1958 , and that death occurred at 4:15 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edgars M. Maculans				ADDRESS (Street, city or town, state) Henryton, Maryland		DATE SIGNED 3-31-58	
PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D., Supt.				Henryton State Hospital			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 3 1958		22c. NAME OF CEMETERY OR CREMATORY Sumpter Cemetery, SC		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE C. Charles R. L. Law				ADDRESS 902 Madison Ave		24a. REC'D BY REGISTRAR DATE APR 1 '58	
						24b. REGISTRAR'S SIGNATURE W. L. Smith	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

BUREAU V. S.

APR 1 1958

RECEIVED

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3109

CERTIFICATE OF DEATH

03086

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williams Nursing Home		d. STREET ADDRESS 603 Beverly Road	
3. NAME OF DECEASED (Type or print) First Agnes Middle E. Last Catterson		4. DATE OF DEATH Month March Day 24 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1870
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 03 Days 12 Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Penna	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nathan R. Jewett		14. MOTHER'S MAIDEN NAME Salome VanHusen	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-14-3303	
17. INFORMANT Mrs. Guy Lewis, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Constrictive Heart Failure, acute DUE TO (c) Arteriosclerosis, generalized		INTERVAL BETWEEN ONSET AND DEATH 30 min. 30 min. 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 01 p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August , 19 57 , to March 24 , 19 58 , that I last saw the deceased alive on March 24 , 19 58 , and that death occurred at 1:40 P. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence E. Williams, M.D.		ADDRESS (Street, city or town, state) Reisterstown, Maryland	
PHYSICIAN'S NAME (Type) Clarence E. Williams		DATE SIGNED March 24/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 27/58	
22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE DATE			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH	
11. PLACE OF DEATH		12. NAME OF PHYSICIAN		13. NAME OF FUNERAL HOME		14. NAME OF BURIAL PLACE		15. NAME OF MINISTER	
16. NAME OF WITNESS		17. NAME OF WITNESS		18. NAME OF WITNESS		19. NAME OF WITNESS		20. NAME OF WITNESS	
21. NAME OF WITNESS		22. NAME OF WITNESS		23. NAME OF WITNESS		24. NAME OF WITNESS		25. NAME OF WITNESS	
26. NAME OF WITNESS		27. NAME OF WITNESS		28. NAME OF WITNESS		29. NAME OF WITNESS		30. NAME OF WITNESS	
31. NAME OF WITNESS		32. NAME OF WITNESS		33. NAME OF WITNESS		34. NAME OF WITNESS		35. NAME OF WITNESS	
36. NAME OF WITNESS		37. NAME OF WITNESS		38. NAME OF WITNESS		39. NAME OF WITNESS		40. NAME OF WITNESS	
41. NAME OF WITNESS		42. NAME OF WITNESS		43. NAME OF WITNESS		44. NAME OF WITNESS		45. NAME OF WITNESS	
46. NAME OF WITNESS		47. NAME OF WITNESS		48. NAME OF WITNESS		49. NAME OF WITNESS		50. NAME OF WITNESS	
51. NAME OF WITNESS		52. NAME OF WITNESS		53. NAME OF WITNESS		54. NAME OF WITNESS		55. NAME OF WITNESS	
56. NAME OF WITNESS		57. NAME OF WITNESS		58. NAME OF WITNESS		59. NAME OF WITNESS		60. NAME OF WITNESS	
61. NAME OF WITNESS		62. NAME OF WITNESS		63. NAME OF WITNESS		64. NAME OF WITNESS		65. NAME OF WITNESS	
66. NAME OF WITNESS		67. NAME OF WITNESS		68. NAME OF WITNESS		69. NAME OF WITNESS		70. NAME OF WITNESS	
71. NAME OF WITNESS		72. NAME OF WITNESS		73. NAME OF WITNESS		74. NAME OF WITNESS		75. NAME OF WITNESS	
76. NAME OF WITNESS		77. NAME OF WITNESS		78. NAME OF WITNESS		79. NAME OF WITNESS		80. NAME OF WITNESS	
81. NAME OF WITNESS		82. NAME OF WITNESS		83. NAME OF WITNESS		84. NAME OF WITNESS		85. NAME OF WITNESS	
86. NAME OF WITNESS		87. NAME OF WITNESS		88. NAME OF WITNESS		89. NAME OF WITNESS		90. NAME OF WITNESS	
91. NAME OF WITNESS		92. NAME OF WITNESS		93. NAME OF WITNESS		94. NAME OF WITNESS		95. NAME OF WITNESS	
96. NAME OF WITNESS		97. NAME OF WITNESS		98. NAME OF WITNESS		99. NAME OF WITNESS		100. NAME OF WITNESS	

RECEIVED
MAR 18 1953
BUREAU V. S.

3111

CERTIFICATE OF DEATH

03088

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>122 CITY VIEW AVE.</u>		d. STREET ADDRESS <u>122 CITY VIEW AVE.</u>	
3. NAME OF DECEASED (Type or print) <u>MAE EGERTON</u> First Middle Last		4. DATE OF DEATH <u>MARCH 12 1958</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 27. 1882</u> 76 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>N.D.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN B. EGERTON</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE FOWLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-05-3850</u>	
17. INFORMANT <u>A.H. DION</u> Address <u>122 CITY VIEW AVE. WESTMINSTER, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhages</u> DUE TO <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 mos.</u> DUE TO (c) <u>5 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>3 Large Decubitus ulcers</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20b. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 1958</u> to <u>Mar. 12, 1958</u> , that I last saw the deceased alive on <u>Mar. 11, 1958</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Reese Wilkins</u>		DATE SIGNED <u>15 Kemper Ave. Md.</u>	
PHYSICIAN'S NAME (Type) <u>E. Reese Wilkins</u>		<u>Westminster</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-15-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GREEN MOUNT CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David A. Bankard</u>		24. REC'D BY REGISTRAR <u>Mar 18 58</u>	
ADDRESS <u>Westminster Md.</u>		25. REGISTRAR'S SIGNATURE <u>W. L. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

BUREAU V. S.

MAR 12 1953

RECEIVED

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03089

3112

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Finksburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown 03X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williams Home		d. STREET ADDRESS 35 Westminster Road	
3. NAME OF DECEASED (Type or print) First Virginia Middle Jennie Last Eierman		4. DATE OF DEATH Month March Day 5 , Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1866
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John W. Lawson		14. MOTHER'S MAIDEN NAME Charlotte Baublitz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-05-6263D	
17. INFORMANT Mrs. Melvin Ramsburg		Address Reisterstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Premia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C.V. Disease DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 24 hrs. years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January , 19 54 , to March 5 , 19 58 , that I last saw the deceased alive on March 4 , 19 58 , and that death occurred at 10 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin E. Strobel		ADDRESS (Street, city or town, state) 48 Main St. Reisterstown Md.	
PHYSICIAN'S NAME (Type) MARTIN E. STROBEL, M.D.		DATE SIGNED 3/5/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF March 7, 58	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cme.		22d. LOCATION (City, town, or county) (State) Carroll County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons		ADDRESS Reisterstown, Md.	
24a. REC'D BY REGISTRAR DATE MAR 7 '58		24b. REGISTRAR'S SIGNATURE Alf. Leach	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

MAINTAIN STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

DECEASED

DATE OF DEATH

PLACE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

BUREAU V. S.

MAR 7 1958

RECEIVED

3113

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1 month 24 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 715 S. Lakewood Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Anna Middle Mary Last ETMANSKI				4. DATE OF DEATH Month March Day 4 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-19-66	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Former Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Etmanski				14. MOTHER'S MAIDEN NAME Mary			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) -				16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield State Hospital Record	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) -							
INTERVAL BETWEEN ONSET AND DEATH Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with senile brain disease, with psychotic reaction							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 10, 1958 to March 4, 1958 , that I last saw the deceased alive on March 4, 1958 , and that death occurred at 2:55 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus				ADDRESS (Street, city or town, state) Springfield State Hospital			
DATE SIGNED 3/4/58							
PHYSICIAN'S NAME (Type) Dr. Edmund Lusthaus				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-8-58		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, town, or county) (State) Dundalk Ave. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda				ADDRESS 2829 Hudson St. 24, Md.		24a. REC'D BY REGISTRAR DATE MAR 11 '58	
24b. REGISTRAR'S SIGNATURE Overseer							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
MAR 11 1953

3114

CERTIFICATE OF DEATH

Reg. Dist. No. 03091

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Mt. Airy				c. LENGTH OF STAY IN 1b 42 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First GRACE Middle JANE Last FARVER				4. DATE OF DEATH Month MARCH Day 18 Year 1958			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 1, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME Ephraim B. Condon				14. MOTHER'S MAIDEN NAME Ruth E. Penn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Robert T. Farver, Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest, Cardiac failure, 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) dehydrated malleus, Cerebral thrombosis, DUE TO (c) dilatation severe, Arteriosclerosis Generalized							INTERVAL BETWEEN ONSET AND DEATH 1957 70 18 March 58
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from Dec 1957, to 18 March 1958, that I last saw the deceased alive on 18 March 1958, and that death occurred at 5:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Howard E. Hall				ADDRESS (Street, city or town, state) Sykesville, Md			
DATE SIGNED 18 March 58							
PHYSICIAN'S NAME (Type) HOWARD E. HALL							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-22-1958		22c. NAME OF CEMETERY Taylorville		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,				ADDRESS Winfield, Maryland		24a. REC'D BY REGISTRAR DATE MAR 26 '58	
24b. REGISTRAR'S SIGNATURE W. E. Beach							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		STATE		COUNTRY	
JAMES H. HARRIS		MALE		45		JAN 15 1913		BALTIMORE		MD		USA			
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		MARRIED		SINGLE		WIDOWED	
WHITE		WHITE		METHODIST		HIGH SCHOOL		LABORER		YES		NO		NO	
MOTHER'S NAME		FATHER'S NAME		MOTHER'S MARRIED		FATHER'S MARRIED		MOTHER'S DECEASED		FATHER'S DECEASED		MOTHER'S SURVIVED		FATHER'S SURVIVED	
MARY H. HARRIS		JOHN H. HARRIS		YES		YES		YES		YES		YES		YES	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH		CERTIFICATE OF DEATH	
MAR 10 1958		BALTIMORE		HEART DISEASE		NATURAL		YES		YES		YES		YES	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

BUREAU K 8

MAR 26 1958

RECEIVED

3115

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) 171 o. STATE Maryland b. COUNTY Montgomery County			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital.				d. STREET ADDRESS 12915 Georgia Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Hallie Middle Cowell Last Ford				4. DATE OF DEATH Month 3 Day 16 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-8-96		9. AGE (In years last birthday) 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sylvester Cowell				14. MOTHER'S MAIDEN NAME Flora ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Hospital records.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Alzheimer's disease 305X Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) Rheumatic heart disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH years. Years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Presenile brain disease with psychotic reaction						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-1- 19 57 , to 3-16 19 58 , that I last saw the deceased alive on 3-16 19 58 , and that death occurred at 3.10 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Agustin del Campo Sr. M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital.		DATE SIGNED 3-16-58	
PHYSICIAN'S NAME (Type) Agustin del Campo, Md.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-19-58		22c. NAME OF CEMETERY OR CREMATORY Cowell		22d. LOCATION (City, town, or county) (State) Doswell, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Luther H. Haight Sykesville, Md.				24a. READ BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 22 1953

REF A 5024

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03093

Reg. Dist. No.

FOR STATE HEALTH DEPT.

M

3116

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 26 yrs. 9 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3 Vol-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS 1721 Covington St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Winifred Middle E. Last FRANCE			4. DATE OF DEATH Month March Day 24 , Year 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 29, 1904		9. AGE (in years last birthday) 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bundle wrapper		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Charles A. France		
14. MOTHER'S MAIDEN NAME Mary E. Harvey			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		
16. SOCIAL SECURITY NO. -			17. INFORMANT Address Springfield Hospital Records		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia 692.6 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cellulitis of neck and buttocks (c) Bronchopneumonia					INTERVAL BETWEEN ONSET AND DEATH Weeks Weeks Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, hebephrenic type. Intertrochanteric fracture, left femur. 904.7					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell while leaving dining room.			
20c. TIME OF INJURY Month, Day, Year 12:40 2/9 58 Hour 12:40 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James T. Marsh</i>		EXAMINER'S NAME (Type) James T. Marsh, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 3/24/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3-26-58	22c. NAME OF CEMETERY OR CREMATORY Western Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS 1217 St. Paul Street		24a. RECEIVED BY REGISTRAR MAR 26 '58	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

Form with multiple sections for medical examination, including fields for name, age, sex, race, occupation, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

MAR 26 1958

RECEIVED

3117 CERTIFICATE OF DEATH

03095

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b 8yrs. 11mos. 23days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital			
d. STREET ADDRESS ---				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle - Last GRELLER				4. DATE OF DEATH Month March Day 18 Year 19 58			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-8-76		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months - Days - Hours - Min. -	IF UNDER 24 HRS. Months - Days - Hours - Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Nicholas Greller				14. MOTHER'S MAIDEN NAME Kate - ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records of Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition, with senile brain disease, without qualifying phrase.		INTERVAL BETWEEN ONSET AND DEATH 2 weeks more than 20 yrs.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. ---		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---		20f. (City or town) (County) (State) ---	
21. I certify that I attended the deceased from March 23, 1949 , to March 18, 1958 , that I last saw the deceased alive on March 18, 1958 , and that death occurred at 12:40 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Martin Gross				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Martin Gross, M. D.				DATE SIGNED 3/19/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-58		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur A. Straight Sykesville, Md.				24a. RECEIVED BY REGISTRAR DATE MAR 27 1958		24b. REGISTRAR'S SIGNATURE C. H. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

3118

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville				c. LENGTH OF STAY IN 1b 18 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DAVID Middle A. Last GROOMES				4. DATE OF DEATH Month MARCH Day 1 Year 1958			
5. SEX male	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-6-1882		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY gen.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Nicholas Groomes				14. MOTHER'S MAIDEN NAME Ellen Sears			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-07-0396		17. INFORMANT Mrs. Anna R. Groomes, Same Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cornary thrombosis, Cardiac failure, 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anemia, Ca of colon, Ca of prostate, DUE TO (c) Arteriosclerosis generalized						INTERVAL BETWEEN ONSET AND DEATH 1957 to 1 March 58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1957 , to 1 March 1958 , that I last saw the deceased alive on 1 March 1958 , and that death occurred at 9:50 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Howard E. Hall M.D.				ADDRESS (Street, city or town, state) Sheswell, Md		DATE SIGNED 3 March 58	
PHYSICIAN'S NAME (Type) HOWARD E. HALL							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-4-1958		22c. NAME OF CEMETERY White Rock		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz, ADDRESS Winfield, Maryland				24a. REC'D BY REGISTRAR DATE MAR 5 58		24b. REGISTRAR'S SIGNATURE W. S. ...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

3119

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD 1 WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER 27</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEADOW VIEW CONV. HOME</u>				d. STREET ADDRESS <u>182 PENNA. AVE.</u>			
3. NAME OF DECEASED (Type or print) <u>JOHN CHARLES HALTER</u> First Middle Last				4. DATE OF DEATH <u>MARCH 11 1958</u> Month Day Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1-14-1877</u>	9. AGE (In years last birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER RET.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN CHARLES HALTER</u>				14. MOTHER'S MAIDEN NAME <u>SARAH ELIZABETH HANN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-14-5142</u>			
				17. INFORMANT <u>Gertrude Halter</u> Address <u>182 Penna Ave. Westminster, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia, Nephrotic chr</u> <u>611X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prothrombin (chr)</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>10 yrs.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 1945</u> to <u>May 11, 1958</u> , that I last saw the deceased alive on <u>March 11, 1958</u> , and that death occurred at <u>10:45 M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm C Jennette</u> M.D.				ADDRESS (Street, city or town, state) <u>103 E Main Westminster Md.</u> DATE SIGNED <u>4-12-58</u>			
PHYSICIAN'S NAME (Type) <u>Wm Carl Jennette M.D.</u>				<u>Westminster Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR. 13-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL GARDENS</u>		22d. LOCATION (City, town, or county) (State) <u>FINNLSBURG MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Darral Bankard</u> ADDRESS <u>Westminster Md.</u>				24a. REC'D BY REGISTRAR <u>MAR 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Deborah</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

MAR 18 1953

RECEIVED

3120

CERTIFICATE OF DEATH

Reg. Dist. No.

03098

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 2mo. 21days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. STREET ADDRESS 102 S. Reed St.	
3. NAME OF DECEASED (Type or print) First August Middle Charles Last Hensen		4. DATE OF DEATH Month March Day 20 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 6, 1883
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad worker Foreman Pattern Shop		10b. KIND OF BUSINESS OR INDUSTRY B & O R R	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unknown	
16. SOCIAL SECURITY NO. 705-10-1808		17. INFORMANT Springfield State Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X not DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterioclerotic heart disease DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH days years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis with psychotic reaction			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 27, 1957 , to March 20, 1958 , that I last saw the deceased alive on March 20, 1958 , and that death occurred at 10:30 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3/21/1958			
ACTUAL SIGNATURE Agustin del Campo M.D.		PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/25/58	22c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.
22d. LOCATION (City, town, or county) (State) Balto., Md.		23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker & Sons Balto 17 Md	
24a. REC'D BY REGISTRAR DATE MAR 26 '58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	
JAMES H. HARRIS		Male		45		White		1913		Baltimore, Md.		1958		Baltimore, Md.		Heart Disease		Natural		J. H. Harris		J. H. Harris	
13. OCCUPATION		14. EDUCATION		15. RELIGION		16. MARITAL STATUS		17. PREVIOUS ILLNESS		18. PREVIOUS SURGERY		19. PREVIOUS TRAUMA		20. PREVIOUS DRUGS		21. PREVIOUS ALCOHOL		22. PREVIOUS TOBACCO		23. PREVIOUS OTHER		24. PREVIOUS OTHER	
Teacher		High School		Catholic		Married		None		None		None		None		None		None		None		None	
25. SIGNATURE OF REGISTRAR		26. SIGNATURE OF DECEASED		27. SIGNATURE OF WITNESS		28. SIGNATURE OF WITNESS		29. SIGNATURE OF WITNESS		30. SIGNATURE OF WITNESS		31. SIGNATURE OF WITNESS		32. SIGNATURE OF WITNESS		33. SIGNATURE OF WITNESS		34. SIGNATURE OF WITNESS		35. SIGNATURE OF WITNESS		36. SIGNATURE OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

RECEIVED
MAR 27 1958
BUREAU Y. H.

3121

Item 9 Film G226 3-13

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>1yr. 9 months, 26 days</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u> <u>1232.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>1229 Jackson St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Ella</u> Last <u>HOHMAN</u>				4. DATE OF DEATH Month <u>March</u> Day <u>4</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-17-78</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Hohman</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Nueman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Springfield State Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>002X</u> Not DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary tuberculosis, moderately advanced, active.</u> DUE TO (c) <u>-</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u> <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 8</u> , 19 <u>56</u> , to <u>March 4</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 4</u> , 19 <u>58</u> , and that death occurred at <u>8:20 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>-</u>							
ACTUAL SIGNATURE <u>Edmund Lusthaus</u> M.D. <u>Springfield State Hospital</u>				PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus, M.D.</u> <u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, RECOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/10/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BALTO CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul A. Heemann</u> ADDRESS <u>6067 Harford Rd.</u>				24a. REC'D BY REGISTRAR <u>W. S. Smith</u> DATE <u>MAR 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

MAR 10 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3122

CERTIFICATE OF DEATH

03100

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	c. LENGTH OF STAY IN 1b <u>YEARS</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X UNION BRIDGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>DEIGHLO BLANCHE HOLLENBAUGH</u>		4. DATE OF DEATH Month Day Year <u>MARCH 17 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/15/1896</u>
9. AGE (In years lost birthday) yrs. <u>61</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE KEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>
13. FATHER'S NAME <u>JOHN JENSENEY</u>		14. MOTHER'S MAIDEN NAME <u>MARY PARRISH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-188443</u>	
17. INFORMANT <u>FE. HOLLENBAUGH, UNION BRIDGE MD</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Influenza Pneumonia</u> <u>480X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. <u>9</u> p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Mar 5</u> , 19 <u>58</u> , to <u>Mar 17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Mar 17</u> , 19 <u>58</u> , and that death occurred at <u>9:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Legg</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Union Bridge 3/17/58</u>	
PHYSICIAN'S NAME (Type) <u>J. H. LEGG MD</u>		<u>Union Bridge Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3/19/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. VIEW CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>UNION BRIDGE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. D. Stark & Sons Union Bridge Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 20 '58</u>	24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1. NAME OF DECEASED WILLIAM J. BROWN		2. SEX MALE		3. AGE 65		4. PLACE OF BIRTH NEW YORK	
5. DATE OF DEATH MARCH 15, 1958		6. TIME OF DEATH 10:30 AM		7. PLACE OF DEATH HOME		8. CAUSE OF DEATH HEART DISEASE	
9. DISEASE OR INJURY HEART DISEASE		10. MANNER OF DEATH NATURAL		11. SIGNATURE OF PHYSICIAN DR. J. H. SMITH		12. SIGNATURE OF REGISTRAR JOHN D. BROWN	
13. SIGNATURE OF DECEASED WILLIAM J. BROWN		14. SIGNATURE OF NEXT OF KIN MRS. J. H. BROWN		15. SIGNATURE OF WITNESS DR. J. H. SMITH		16. SIGNATURE OF WITNESS JOHN D. BROWN	
17. SIGNATURE OF WITNESS DR. J. H. SMITH		18. SIGNATURE OF WITNESS JOHN D. BROWN		19. SIGNATURE OF WITNESS DR. J. H. SMITH		20. SIGNATURE OF WITNESS JOHN D. BROWN	
21. SIGNATURE OF WITNESS DR. J. H. SMITH		22. SIGNATURE OF WITNESS JOHN D. BROWN		23. SIGNATURE OF WITNESS DR. J. H. SMITH		24. SIGNATURE OF WITNESS JOHN D. BROWN	
25. SIGNATURE OF WITNESS DR. J. H. SMITH		26. SIGNATURE OF WITNESS JOHN D. BROWN		27. SIGNATURE OF WITNESS DR. J. H. SMITH		28. SIGNATURE OF WITNESS JOHN D. BROWN	
29. SIGNATURE OF WITNESS DR. J. H. SMITH		30. SIGNATURE OF WITNESS JOHN D. BROWN		31. SIGNATURE OF WITNESS DR. J. H. SMITH		32. SIGNATURE OF WITNESS JOHN D. BROWN	
33. SIGNATURE OF WITNESS DR. J. H. SMITH		34. SIGNATURE OF WITNESS JOHN D. BROWN		35. SIGNATURE OF WITNESS DR. J. H. SMITH		36. SIGNATURE OF WITNESS JOHN D. BROWN	
37. SIGNATURE OF WITNESS DR. J. H. SMITH		38. SIGNATURE OF WITNESS JOHN D. BROWN		39. SIGNATURE OF WITNESS DR. J. H. SMITH		40. SIGNATURE OF WITNESS JOHN D. BROWN	
41. SIGNATURE OF WITNESS DR. J. H. SMITH		42. SIGNATURE OF WITNESS JOHN D. BROWN		43. SIGNATURE OF WITNESS DR. J. H. SMITH		44. SIGNATURE OF WITNESS JOHN D. BROWN	
45. SIGNATURE OF WITNESS DR. J. H. SMITH		46. SIGNATURE OF WITNESS JOHN D. BROWN		47. SIGNATURE OF WITNESS DR. J. H. SMITH		48. SIGNATURE OF WITNESS JOHN D. BROWN	
49. SIGNATURE OF WITNESS DR. J. H. SMITH		50. SIGNATURE OF WITNESS JOHN D. BROWN		51. SIGNATURE OF WITNESS DR. J. H. SMITH		52. SIGNATURE OF WITNESS JOHN D. BROWN	
53. SIGNATURE OF WITNESS DR. J. H. SMITH		54. SIGNATURE OF WITNESS JOHN D. BROWN		55. SIGNATURE OF WITNESS DR. J. H. SMITH		56. SIGNATURE OF WITNESS JOHN D. BROWN	
57. SIGNATURE OF WITNESS DR. J. H. SMITH		58. SIGNATURE OF WITNESS JOHN D. BROWN		59. SIGNATURE OF WITNESS DR. J. H. SMITH		60. SIGNATURE OF WITNESS JOHN D. BROWN	
61. SIGNATURE OF WITNESS DR. J. H. SMITH		62. SIGNATURE OF WITNESS JOHN D. BROWN		63. SIGNATURE OF WITNESS DR. J. H. SMITH		64. SIGNATURE OF WITNESS JOHN D. BROWN	
65. SIGNATURE OF WITNESS DR. J. H. SMITH		66. SIGNATURE OF WITNESS JOHN D. BROWN		67. SIGNATURE OF WITNESS DR. J. H. SMITH		68. SIGNATURE OF WITNESS JOHN D. BROWN	
69. SIGNATURE OF WITNESS DR. J. H. SMITH		70. SIGNATURE OF WITNESS JOHN D. BROWN		71. SIGNATURE OF WITNESS DR. J. H. SMITH		72. SIGNATURE OF WITNESS JOHN D. BROWN	
73. SIGNATURE OF WITNESS DR. J. H. SMITH		74. SIGNATURE OF WITNESS JOHN D. BROWN		75. SIGNATURE OF WITNESS DR. J. H. SMITH		76. SIGNATURE OF WITNESS JOHN D. BROWN	
77. SIGNATURE OF WITNESS DR. J. H. SMITH		78. SIGNATURE OF WITNESS JOHN D. BROWN		79. SIGNATURE OF WITNESS DR. J. H. SMITH		80. SIGNATURE OF WITNESS JOHN D. BROWN	
81. SIGNATURE OF WITNESS DR. J. H. SMITH		82. SIGNATURE OF WITNESS JOHN D. BROWN		83. SIGNATURE OF WITNESS DR. J. H. SMITH		84. SIGNATURE OF WITNESS JOHN D. BROWN	
85. SIGNATURE OF WITNESS DR. J. H. SMITH		86. SIGNATURE OF WITNESS JOHN D. BROWN		87. SIGNATURE OF WITNESS DR. J. H. SMITH		88. SIGNATURE OF WITNESS JOHN D. BROWN	
89. SIGNATURE OF WITNESS DR. J. H. SMITH		90. SIGNATURE OF WITNESS JOHN D. BROWN		91. SIGNATURE OF WITNESS DR. J. H. SMITH		92. SIGNATURE OF WITNESS JOHN D. BROWN	
93. SIGNATURE OF WITNESS DR. J. H. SMITH		94. SIGNATURE OF WITNESS JOHN D. BROWN		95. SIGNATURE OF WITNESS DR. J. H. SMITH		96. SIGNATURE OF WITNESS JOHN D. BROWN	
97. SIGNATURE OF WITNESS DR. J. H. SMITH		98. SIGNATURE OF WITNESS JOHN D. BROWN		99. SIGNATURE OF WITNESS DR. J. H. SMITH		100. SIGNATURE OF WITNESS JOHN D. BROWN	

RECEIVED
MAR 20 1958
BUREAU V. B.

3123

CERTIFICATE OF DEATH

Reg. Dist. No.

03101

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b 4 mos. 15 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Gaithersburg - RFD #1			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First John Middle Alphus Last HOWARD				4. DATE OF DEATH Month March Day 19 Year 1958			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH October 22, 1870	
9. AGE (In years lost birthday) 87 yrs.		IF UNDER 1 YEAR Months 8 Days 15 Hours 2 Min.		IF UNDER 24 HRS. Months 8 Days 15 Hours 2 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME Joseph Howard				14. MOTHER'S MAIDEN NAME Elizabeth Johnson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records of Springfield State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 1 day more than 4 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from November 4, 1957 , to March 19, 1958 , that I last saw the deceased alive on March 19, 1958 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Martin Gross M.D. Springfield State Hospital 3/19/58 PHYSICIAN'S NAME (Type) Martin Gross, M. D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/23/58		22c. NAME OF CEMETERY OR CREMATORY Damascus Cemetery		22d. LOCATION (City, town, or county) (State) Damascus, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Raymond Barber				ADDRESS Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE MAR 24 '58	
24b. REGISTRAR'S SIGNATURE Raymond Barber							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES V. BUREAU		45		M		W		MAY 24 1958		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
1000 N. E. ST.		LABORER		HEART DISEASE		NATURAL		1000		YES	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		PREVIOUS SURGERY	
MAY 24 1913		BALTIMORE, MD		HIGH SCHOOL		MAY 1945		NO		NO	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE NO.		REGISTERED	
MAY 24 1958		BALTIMORE, MD		HEART DISEASE		NATURAL		1000		YES	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		PREVIOUS ILLNESS		PREVIOUS SURGERY	
MAY 24 1913		BALTIMORE, MD		HIGH SCHOOL		MAY 1945		NO		NO	

BUREAU V. S.

MAR 24 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3098

CERTIFICATE OF DEATH

Reg. Dist. No. **03102**

1. PLACE OF DEATH o. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE MD. b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 3 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 67 PENNA AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IDA First MANDILLA Middle HYLE Last		4. DATE OF DEATH MARCH 19 Month 19 Day 58 Year	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-20-1873
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR: Months 85 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MD.	
11. BIRTHPLACE (State or foreign country) MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEWIS BAUMGARDNER		14. MOTHER'S MAIDEN NAME SOPHIE McHALEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. #	
17. INFORMANT CLARENCE HYLE WESTMINSTER		Address 67 Penna Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA LUNG 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARCINOMA BREAST DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH 15 mo + YEARS.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1950, to MARCH 19 1958 , that I last saw the deceased alive on MAR 18 , 19 58 , and that death occurred at 2 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 2-20-58			
ACTUAL SIGNATURE James J. Marsh M.D.		PHYSICIAN'S NAME (Type) JAMES I. MARSH WESTMINSTER MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF MARCH 21 1958	22c. NAME OF CEMETERY OR CREMATORY TRIDERS REEF CEM.	22d. LOCATION (City, town, or county) (State) WESTMINSTER MD
23. FUNERAL DIRECTOR'S SIGNATURE David Bankard ADDRESS Westminster, Md.		24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE Out

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3124

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Balto.City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 1yr.5mos.17days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3906 Groveland Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katharine Middle Biddison Last IMMLER				4. DATE OF DEATH Month March Day 27 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH August 11, 1901	9. AGE (In years lost birthday) 56 yrs.	IF UNDER 1 YEAR Months 56 Days 56 Hours 56 Min.	IF UNDER 24 HRS. Months 56 Days 56 Hours 56 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher (rtd)		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Zachariah Biddison				14. MOTHER'S MAIDEN NAME Anna Katharine Kahl			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) -		16. SOCIAL SECURITY NO. 216-18-7098		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung abscess 521X X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Bilateral bronchopneumonia. X DUE TO (c) Pick's Disease of the brain						INTERVAL BETWEEN ONSET AND DEATH Days Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with other diseases of unknown or uncertain cause with psychotic reaction. 471X						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 Month, Day, Year a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Springfield State Hospital		(County) (State)	
21. I certify that I attended the deceased from October 10, 19 56 , to March 27, 19 58 , that I last saw the deceased alive on March 26, 19 58 , and that death occurred at 2:15 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3/27/58							
ACTUAL SIGNATURE Agustin del Campo		M.D. Springfield State Hospital		DATE SIGNED 3/27/58			
PHYSICIAN'S NAME (Type) Agustin del Campo, M.D.		Sykesville, Maryland.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/31/58	22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		22d. LOCATION (City, town, or county) (State) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lechner & Sons - Balto - 17 Md.				ADDRESS Baltimore, Md.		24b. REGISTRAR'S SIGNATURE Outmail	
24a. REC'D BY REGISTRAR DATE APR 1 58				24b. REGISTRAR'S SIGNATURE Outmail			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		PLACE OF DEATH [Faint text]	
OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]	
SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]	
CITY [Faint text]		COUNTY [Faint text]	
STATE [Faint text]		ZIP CODE [Faint text]	

BUREAU V. S.

APR 1 1953

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3125

CERTIFICATE OF DEATH

03105

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2mos. 21days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 212 E. Irvin Ave.			
3. NAME OF DECEASED (Type or print) First Hedwig Middle Theis Last KAISER				4. DATE OF DEATH Month March Day 27 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 29, 1873	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Germany	
12. CITIZEN OF WHAT COUNTRY? Unknown ✓							
13. FATHER'S NAME Gottlieb Theis				14. MOTHER'S MAIDEN NAME Amalie Kasbach			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No				16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO 420.0 Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from January 6, 1958 , to March 27, 1958 , that I last saw the deceased alive on March 27, 1958 , and that death occurred at 12: Noon , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3/27/58 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Mar. 31, 1958		22c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park	
22d. LOCATION (City, town, or county) Parkville, Md.				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.				24a. REC'D BY REGISTRAR DATE APR 7 58		24b. REGISTRAR'S SIGNATURE W. Kasbach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		1883		Maryland	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH	
1234 Main St.		Farmer		Heart Disease		Natural		April 5, 1958	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE		PULSE	
April 5, 1958		Home		10:00 AM		98.6		60	
TIME OF DEATH		TEMPERATURE		PULSE		BLOOD PRESSURE		SPECIAL EXAMINATIONS	
10:00 AM		98.6		60		120/80		None	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

RECEIVED
 APR 7 1958
 BUREAU V. S.

3126

CERTIFICATE OF DEATH

03104

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 6 y 2 m 4 d			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Randolph Last Keene				4. DATE OF DEATH Month 3 Day 15 Year 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9-16-78	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert Keene				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) unkn				16. SOCIAL SECURITY NO. unkn		17. INFORMANT Mary Frances Tall Address Springfield Hosp. Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 491X XXXX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerotic heart disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH days years							
Chronic Atherosclerosis without psychosis, but with signs of Arteriosclerosis Chron. fibrous pulmonary Tuberculosis, prob. inactive, Possible Ca of bladder							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 002X			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Oct. 20, 1954 , to March 14, 1958 , that I last saw the deceased alive on XXX 3 - 14 - 1958 , and that death occurred at 2:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Springfield State Hospital DATE SIGNED 3-15-58							
ACTUAL SIGNATURE Edmund Lusthaus				PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3/18/1958		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
22d. LOCATION (City, town, or county) Baltimore Maryland				22e. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				24a. REC'D BY REGISTRAR DATE MAR 17 '58		24b. REGISTRAR'S SIGNATURE Al L. Smith	
Ellsworth Armacost-4600 Liberty Heights Ave.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The text is mirrored and difficult to read.

BUREAU V. 2

MAR 17 1958

RECEIVED

3127

CERTIFICATE OF DEATH

Reg. Dist. No.

03106

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>1 month 4 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>107 S. Dean Street</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>William</u> Last <u>KRIEG</u>				4. DATE OF DEATH Month <u>March</u> Day <u>5</u> Year <u>19 58</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-2-86</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A. Baltimore</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Peter Krieg</u>			
14. MOTHER'S MAIDEN NAME <u>Leona</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>1908</u>			
16. SOCIAL SECURITY NO. <u>-</u>				17. INFORMANT <u>SPRINGFIELD STATE HOSPITAL RECORDS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>420.0</u> Not DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Years</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491.6 CBS associated with cerebral arteriosclerosis, with psychotic reaction</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January 31, 19 58</u> , to <u>March 5, 19 58</u> , that I last saw the deceased alive on <u>March 5, 19 58</u> , and that death occurred at <u>12:55 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>3/5/58</u> ACTUAL SIGNATURE <u>Agustin del Campo</u> M.D. <u>Springfield State Hospital</u> PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u> <u>Sykesville, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 10, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS <u>Ellsworth Armacost-4600 Liberty Hghts. Ave.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 10 58</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

E. coli

RECEIVED

3128

Item 14 Film G226 3-13-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b Baltimore 3Y01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3438 Reisterstown Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Jennie Middle Bender Last Kroopnick				4. DATE OF DEATH Month March Day 5 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1880		9. AGE (In years lost birthday) 77 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Reuben Bender				14. MOTHER'S MAIDEN NAME Unobtainable			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Springfield State Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) Diabetes				INTERVAL BETWEEN ONSET AND DEATH Mins. Years Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Manic Depressive Reaction, other.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 11 , 19 42 , to March 5 , 19 58 , that I last saw the deceased alive on March 4 , 19 58 , and that death occurred at 2:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3/5/58							
ACTUAL SIGNATURE Gertrud Sonnenfeldt				M.D. Springfield State Hospital			
PHYSICIAN'S NAME (Type) Gertrud Sonnenfeldt, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 7/58		22c. NAME OF CEMETERY OR CREMATORY Shaarei Zion		22d. LOCATION (City, town, or county) (State) Bald, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Sol Lewinson & Bros Inc				ADDRESS W. North Ave 1124-26		24a. REC'D BY REGISTRAR W. North	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Reg. Dist. No.

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 45		4. DATE OF BIRTH Jan 15 1900		5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Teacher	
7. MARITAL STATUS Married		8. COLOR White		9. HEIGHT 5' 8"		10. WEIGHT 160		11. BUILD Medium		12. COMPLEXION Fair	
13. EDUCATION High School		14. RELIGION Catholic		15. PRESENT ADDRESS 123 Main St., Baltimore, Md.		16. DATE OF DEATH Mar 10 1933		17. PLACE OF DEATH Home		18. CAUSE OF DEATH Heart Disease	
19. MEDICAL HISTORY None		20. SURGICAL HISTORY None		21. PRESENT ILLNESS None		22. DATE OF EXAMINATION Mar 10 1933		23. SIGNATURE OF PHYSICIAN John Doe		24. SIGNATURE OF REGISTRAR John Doe	

BUREAU V. S.

MAR 10 1933

RECEIVED

3129

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 4month13days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cullen 10x-2				✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS --			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Sophie Middle Jeznach Last KUNAWICZ				4. DATE OF DEATH Month March Day 8 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-9-93		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Unknown ✓
13. FATHER'S NAME John Jeznach				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records - Springfield State Hospital			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Rheumatic Heart Disease 416x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Tumor in left frontal lobe of brain - type undetermined. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS associated with convulsive disorder with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 25 , 19 57 , to March 8 , 19 58 , that I last saw the deceased alive on March 7 , 19 58 , and that death occurred at 1:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED ACTUAL SIGNATURE Gertrude M. Gross, M.D. PHYSICIAN'S NAME (Type) Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/12/58		22c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		22d. LOCATION (City, town or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE T. F. Sadowski & Sons, 1808 Eastern Avenue				24a. REC'D BY REGISTRAR DATE MAR 11 '58		24b. REGISTRAR'S SIGNATURE Overhauich	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES EARL RAY		MALE		35		JAN 5 1928		MOBILE		ALABAMA		ALABAMA		ALABAMA	
RACE		COLOR		RELIGION		EDUCATION		OCCUPATION		MANNER OF DEATH		CAUSE OF DEATH		PLACE OF DEATH	
WHITE		WHITE		METHODIST		HIGH SCHOOL		LABORER		SUICIDE		SHOOTING		MOBILE, ALABAMA	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CITY		COUNTY		STATE		CITY		COUNTY	
APR 4 1968		10:00 PM		MOBILE		ALABAMA		ALABAMA		ALABAMA		ALABAMA		ALABAMA	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JUDGE		SIGNATURE OF CLERK		SIGNATURE OF		SIGNATURE OF	

BUREAU V. S.

MAR 11 1968

RECEIVED

3130

CERTIFICATE OF DEATH

03109

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 6 months, 19 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS Unknown			
3. NAME OF DECEASED (Type or print) First Joseph Middle LAN Last CAST				4. DATE OF DEATH Month March Day 28 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years lost birthday) yrs. 70	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Unknown		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the stomach. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 151X DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with senile brain disease, with psychotic reaction.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from September 9, 1957 , to March 28, 1958 , that I last saw the deceased alive on March 28, 1958 , and that death occurred at 10:00A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 3/28/58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M. D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town or county) (State)	
Burial		3-31-58		New Cathedral		Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Wright				ADDRESS Springfield, Md.		24a. REC'D BY REGISTRAR DATE APR 1 1958	
				24b. REGISTRAR'S SIGNATURE Arthur H. Wright			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

APR 1 1958

RECEIVED

CERTIFICATE OF DEATH

3131

REG. DIV. 100

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		MALE		35		WHITE		JAN 5 1928		MEMPHIS, TENN.	
7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
JAN 6 1968		MEMPHIS, TENN.		HEART DISEASE		NATURAL		[Signature]		[Signature]	
13. COUNTY		14. CITY		15. STATE		16. ZIP CODE		17. HOSPITAL		18. OTHER	
MEMPHIS		MEMPHIS		TENN.		38102		[Blank]		[Blank]	
19. MARITAL STATUS		20. OCCUPATION		21. EDUCATION		22. RELIGION		23. SOCIAL SECURITY NO.		24. OTHER	
SINGLE		[Blank]		[Blank]		[Blank]		[Blank]		[Blank]	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF WITNESS		27. SIGNATURE OF PHYSICIAN		28. SIGNATURE OF REGISTRAR		29. SIGNATURE OF CLERK		30. SIGNATURE OF CHIEF	
[Blank]		[Blank]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

MAR 24 1968

RECEIVED

3132

CERTIFICATE OF DEATH

03111

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>MARIE - LEESE</u> First Middle Last		4. DATE OF DEATH <u>March 11</u> Month Day Year <u>1958</u>	
5. SEX <u>FA</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 2-1885</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stitch</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Haines</u>		14. MOTHER'S MAIDEN NAME <u>Emma Wauchem</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-32-4517</u>	
17. INFORMANT <u>Geo W. Leese</u> Address <u>Manchester Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anterograde Heart Disease</u> DUE TO (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 30</u> , 19 <u>48</u> , to <u>March 11</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 11</u> , 19 <u>58</u> , and that death occurred at <u>5:45 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foward</u>		ADDRESS (Street, city or town, state) <u>Manchester, Md</u> DATE SIGNED <u>3/11/58</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Foward MD</u>		<u>Manchester, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 14/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Manchester cem</u>	22d. LOCATION (City, town, or county) (State) <u>Carroll co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Clifton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 17 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Al. Leach</u>	

BUREAU

MAR 17 1958

RECEIVED

3133

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b 15 days		Baltimore 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS 3716 Oakmont Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DOVIE Middle THURSTON ARDELIA Last LOONEY		4. DATE OF DEATH Month 3 Day 20 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 8/23/94
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Taylor		14. MOTHER'S MAIDEN NAME Katherine Looney	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Record, Springfield State Hospital		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH minutes years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 3/5 , 19 58 , to 3/20 , 19 58 , that I last saw the deceased alive on 3/20 , 19 59 , and that death occurred at 9:30P M, from the causes and on the date stated above.					
ACTUAL SIGNATURE Gertrude M. Gross, M.D.		ADDRESS (Street, city or town, state) Sykesville, Maryland		DATE SIGNED 3/21/58	
PHYSICIAN'S NAME (Type) Gertrude M. Gross, M.D.		Sykesville, Maryland, Springfield State			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-23-58		22c. NAME OF CEMETERY OR CREMATORY Livingston	
22d. LOCATION (City, town, or county) Livingston, Va.		(State) Hosp.			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight, Sykesville, Md.		ADDRESS Sykesville, Md.		24. REC'D BY REGISTRAR DATE MAR 24 '58	
24b. REGISTRAR'S SIGNATURE Deborah					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3134

Item 12 Film G226 3-17-58 et

CERTIFICATE OF DEATH

03113

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 90		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City d. STREET ADDRESS 3511 W. Belvedere Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DOMINICK Middle A. Last MANNO		4. DATE OF DEATH Month March Day 10 Year 1958	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 15, 1885 9. AGE (In years last birthday) 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-employed Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber Shop	11. BIRTHPLACE (State or foreign country) Italy
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Josephine Reich, 5215 Wilton Hgts. Av. Balto.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic C.V. Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetic		INTERVAL BETWEEN ONSET AND DEATH 4 months 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. None 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work None	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-29- , 1957 , to 3-10- , 1958 , that I last saw the deceased alive on 3-8-58 , 19____, and that death occurred at 8 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd. Reisterstown, Maryland DATE SIGNED 3-10-58			
ACTUAL SIGNATURE D. D. Caples		M.D. L. Hanner Rd. Reisterstown	
PHYSICIAN'S NAME (Type) Dr. D. D. Caples, M. D.		6 Hanover Rd. Reisterstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Mar. 14, 1958	22c. NAME OF CEMETERY OR CREMATORY Cathedral Cemetery,	22d. LOCATION (City, town, or county) (State) Wilmington, Delaware
23. FUNERAL DIRECTOR'S SIGNATURE B. Vernon Lemon		24a. REC'D BY REGISTRAR 4-12-58	
ADDRESS 4611 Park Hgts. Av. Balto. Md.		24b. REGISTRAR'S SIGNATURE W. Reich	

2501

BUREAU V. S.

MAR 12 1958

RECEIVED

1 Park Lane, A. V. Bullock, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3099

CERTIFICATE OF DEATH

03114

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
c. LENGTH OF STAY IN 1b <u>50 YRS.</u>		d. STREET ADDRESS <u>457 E. GREEN</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>457 E. GREEN ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>IRENE</u> Middle <u>MAY</u> Last <u>MARTIN</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>5</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 8, 1874</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL A. AULTS</u>		14. MOTHER'S MAIDEN NAME <u>MARY A. EBAUGH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>MRS HELEN FARVER</u>		Address <u>1257 E. GIBBY WESTMINSTER MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X Uremia, Myocardial (chr) Hypertension (chr)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May, 1931</u> , to <u>March 5, 1958</u> , that I last saw the deceased alive on <u>Mar. 4, 1958</u> , and that death occurred at <u>7A</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. C. Jesperson</u> M.D.		ADDRESS (Street, city or town, state) <u>103 E Main Westminster Md</u>	
PHYSICIAN'S NAME (Type) <u>Wm Carl Jannette</u>		DATE SIGNED <u>3-7-58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-8-1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LEISTERS LEM</u>		22d. LOCATION (City, town, or county) (State) <u>RD 4 WESTMINSTER MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David C. Bankard</u>		ADDRESS <u>Westminster Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE</u>		24b. REGISTRAR'S SIGNATURE <u>Carl Jannette</u>	

CERTIFICATE OF DEATH

Page Two

DATE OF DEATH

PLACE

CITY OR TOWN

COUNTY

STATE

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

PREVIOUS ILLNESS

CAUSE OF DEATH

MANNER OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF BURIAL

NAME OF FUNERAL

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF SIGNER

NAME OF OFFICIAL

NAME OF CLERK

NAME OF RECORDER

NAME OF INDEXER

NAME OF FILED

NAME OF CHECKED

NAME OF REVIEWED

NAME OF APPROVED

NAME OF SIGNED

NAME OF DATED

NAME OF TIME

NAME OF PLACE

NAME OF STATE

BUREAU V. S.

MAR 10 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03115

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

3135

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 8 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3001-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 3163 Keswick Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Truman Last MATHIAS				4. DATE OF DEATH Month March Day 25 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 9, 1879	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine worker				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardia vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease with psychotic reaction.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James T. Marsh				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James T. Marsh, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 3-31-58		22c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH	
22d. LOCATION (City, town, or county) CARROLL CO				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Chenoweth				ADDRESS 365-17-19 Chestnut		24a. REC'D BY REGISTRAR DATE MAR 27 '58	
24b. REGISTRAR'S SIGNATURE Alfred Marsh							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
APR 1 1955

BUREAU V. S.

BUREAU V. S.

FOR STATE
HEALTH DEPT.



MARYLAND STATE DEPARTMENT OF HEALTH - BOSTON 15
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3136

CERTIFICATE OF DEATH

Reg. Dist. No. 03116

1. PLACE OF DEATH a. COUNTY Carroll County MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 2408 Orleans Street			
3. NAME OF DECEASED (Type or print) First Noland Middle Medinger Last				4. DATE OF DEATH Month 3 Day 16 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-1887	9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Huckster		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Harry Medinger				14. MOTHER'S MAIDEN NAME Julia Bohlfling			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War I		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Hospital Record			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 weeks years						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with senile brain disease, with psychotic reaction.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-14-1958 , 19 58 , to 3-16 , 19 58 , that I last saw the deceased alive on 3-16 , 19 58 , and that death occurred at 10:00 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3-16-1958							
ACTUAL SIGNATURE Gertrude M. Gross, M.D.				M.D. Springfield State Hospital 3-16-1958			
PHYSICIAN'S NAME (Type) Gertrude M. Gross, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3/19/58		22c. NAME OF CEMETERY OR CREMATORY BALTO. NATIONAL CEM.		22d. LOCATION (City, town, or county) (State) BALTO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE Harley Miller				24a. REC'D BY REGISTRAR 2334 Jefferson St.		24b. REGISTRAR'S SIGNATURE DATE MAR 21 '58	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G226 3-6-58 et

3137

CERTIFICATE OF DEATH

Reg. Dist. No.

03117

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 29 y. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3706 Columbus Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Benjamin Merensbloom				4. DATE OF DEATH Month Day Year March 2 1958							
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1885 ?		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harris Merensbloom				14. MOTHER'S MAIDEN NAME Ida Friedman				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Records of the Springfield Stet Hospital				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, Hebephrenic type 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from April 1956 , to March 2 , 1958 , that I last saw the deceased alive on February 27 , 1958 , and that death occurred at 1 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Walter Knopp M.D. Springfield State Hosp, Sykesville, MD ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Walter Knopp March 2, 1958											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 3-3-58		22c. NAME OF CEMETERY OR CREMATORY Rebekah Isaac		22d. LOCATION (City, town, or county) (State) Balto Md			
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis						24a. REC'D BY REGISTRAR 2100 Eutaw Place		24b. REGISTRAR'S SIGNATURE DATE MAR 4 '58			

3138

Item 9 Film G226 3-13-58 et

CERTIFICATE OF DEATH

03118

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton				c. LENGTH OF STAY IN 1b 271 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital				e. STREET ADDRESS 1825 Orleans Street			
3. NAME OF DECEASED (Type or print) First Andy Middle Clarence Last Miles				4. DATE OF DEATH Month March Day 9 Year 1958			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 28, 1908	9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper-Carol's Coal Co.			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Chester, S. C.		
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME Will Miles				
14. MOTHER'S MAIDEN NAME Mary Stewart			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				
16. SOCIAL SECURITY NO. 213-09-3366			17. INFORMANT Andy C. Miles Address 1825 Orleans Street				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Far advanced pulmonary tuberculosis DUE TO (c) Maxillary tumor left, severe anemia						INTERVAL BETWEEN ONSET AND DEATH May, 1957	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from July 11 , 19 57 , to March 9 , 19 58 , that I last saw the deceased alive on March 9 , 19 58 , and that death occurred at 9:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 3-9-58 ACTUAL SIGNATURE Edgars M. Maculans Spt. M.D. PHYSICIAN'S NAME (Type) Dr. Edgars M. Maculans Supt. Henryton State Hospital, Henryton, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/15/58	22c. NAME OF CEMETERY OR CREMATORY Gladden Cemt	22d. LOCATION (City, town, or county) Chester, S. C.				
23. FUNERAL DIRECTOR'S SIGNATURE Randolph J. Pollick			24a. REC'D BY REGISTRAR DATE MAR 11 '58	24b. REGISTRAR'S SIGNATURE Robert R. Swann			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3139

CERTIFICATE OF DEATH

Reg. Dist. No.

03119

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAMPSTEAD MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X HAMPSTEAD MARYLAND</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>305 N. MAIN ST</u>				d. STREET ADDRESS <u>305 N. MAIN ST</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET ANN Miller</u>				4. DATE OF DEATH Month Day Year <u>MARCH 29 1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1885</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
10c. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel Schaffer</u>				14. MOTHER'S MAIDEN NAME <u>Mollie Kelbaugh</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>212-01-8624</u>		17. INFORMANT Address <u>George J. Miller HAMPSTEAD MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Primary Carcinoma of Gall Bladder</u> 155.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 1958			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office Bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>12-17-</u> 19 <u>58</u> , to <u>March 29</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 29</u> , 19 <u>58</u> , and that death occurred at <u>8 A</u> . M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city or town, state) <u>HAMPSTEAD MD</u>		DATE SIGNED <u>3/29/58</u>	
PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD</u>				<u>HAMPSTEAD Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>Apr '58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. E. Lipton</u>				ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 1 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

CERTIFICATE OF DEATH

See Form No. 10

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
John Doe		Male		45		Jan 1, 1913		Jan 15, 1958		Home		Heart Disease		Natural		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual place of work		16. Name of attending physician		17. Name of hospital		18. Name of funeral home		19. Name of undertaker		20. Name of cemetery	
Teacher		High School		Married		123 Main St		ABC Co		Dr. Smith		St. Mary's		Doe & Sons		Doe & Sons		Greenwood	
21. Name of informant		22. Relationship		23. Address		24. City		25. State		26. Zip		27. Date of completion		28. Signature of informant		29. Signature of registrar		30. Signature of physician	
Jane Doe		Wife		123 Main St		Baltimore		Maryland		21204		Jan 15, 1958		[Signature]		[Signature]		[Signature]	

BUREAU V. 3

APR 1 1958

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

3140

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stokesville				c. LENGTH OF STAY IN 1b 1 y 8 m 26 d			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS Reeders Nursing Home							
3. NAME OF DECEASED (Type or print) First Minnie Middle Agnes Last Nicodemus				4. DATE OF DEATH Month 3 Day 29 Year 19 58			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH unkn	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Franklin Delaney				14. MOTHER'S MAIDEN NAME Amelia Kaplan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. unkn		17. INFORMANT Springfield Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Asthma due to Arteriosclerotic heart DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with disturbance of metabolism growth or nutrition with senile brain disease with psychotic reaction							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from 7-3- , 19 56 to 3-29- , 19 58 , that I last saw the deceased alive on 3-29- , 19 58 , and that death occurred at 12:45A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 3-29-58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus M.D.				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF April 2-58		22c. NAME OF CEMETERY OR CREMATORY St. Vincent Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Albert L. Williamsport, Md				24a. REC'D BY REGISTRAR DATE APR 1 '58		24b. REGISTRAR'S SIGNATURE Albert L. Williamsport	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3141

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION MILLS</u>				c. LENGTH OF STAY IN 1b <u>2 MO</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MEADOW VIEW NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FLORENCE ENGLAR NORRIS</u>				4. DATE OF DEATH Month Day Year <u>MAR 12 1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 8-1883</u>	9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ALFRED ENGLAR</u>				14. MOTHER'S MAIDEN NAME <u>ELIZA ROOP</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>EDWIN ENGLAR NEW WINDSOR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial degeneration</u> DUE TO <u>Cancer of breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 1/2 yrs</u> DUE TO <u>(with extensive metastasis)</u> (c) <u>2 yrs</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Sept 1, 1957</u> to <u>Mar 12, 1958</u> , that I last saw the deceased alive on <u>Mar 7, 1958</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Kemler Ave</u> DATE SIGNED <u>3/13/58</u> ACTUAL SIGNATURE <u>Reese Wilkens</u> PHYSICIAN'S NAME (Type) <u>DR. Reese WILKENS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/15/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Dr. Hartman & Sons New Windsor, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Reese Wilkens</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAR 17 1958

RECEIVED

BUREAU 4.3

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

UNITED STATES DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20a Film 227 4-8-58 ams

3142

CERTIFICATE OF DEATH

Reg. Dist. No. 03122

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM</u> <u>VERLY</u> <u>NUSBAUM</u>				4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>31</u> <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 1-1880</u>	9. AGE (In years last birthday) <u>77</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TENANT</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>JOHN NUSBAUM</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>213-18-6448</u>			
17. INFORMANT <u>LESTER NUSBAUM</u>				Address <u>RURAL UNION BRIDGE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Virus Pneumonia</u> <u>492 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>also accident due to fall</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>3/28</u> , 19 <u>58</u> , to <u>3-31-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>3/31</u> , 19 <u>58</u> , and that death occurred at <u>1:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. H. HEGG</u>				ADDRESS (Street, city or town, state) <u>Union Bridge MD</u>			
PHYSICIAN'S NAME (Type) <u>T. H. HEGG MD</u>				DATE SIGNED <u>3/31/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/2/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BAUST CHURCH</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL CO. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Hartzler & Sons</u>				ADDRESS <u>Union Bridge Md</u>		24a. REC'D BY REGISTRAR DATE <u>APR 3 58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. Hartzler</u>			

BUREAU V. 5

APR 3 1958

RECEIVED

3143

CERTIFICATE OF DEATH

Reg. Dist. No. 03123

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Carroll		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 65 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Sykesville, Md			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Obrecht and Gaiters Rd				d. STREET ADDRESS Obrecht and Gaiters Road		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Charles		First Frederick		Middle Obrecht		Last	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 29, 1877	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		9. DATE OF DEATH 3 9 1958	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Obrecht		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT son Philipp C. Obrecht, Sykesville		Address Sykesville		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, from the causes and on the date stated above. 3-9-58, 1958, 4:30 PM		ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 3-9-58			
ACTUAL SIGNATURE Edmund Lusthaus		M.D. Edmund Lusthaus M.D.		Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-12-58		22c. NAME OF CEMETERY OR CREMATORY Springfield		22d. LOCATION (City, town, or county) (State) Sykesville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur W. Haight		ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR DATE MAR 17 '58		24b. REGISTRAR'S SIGNATURE Paul	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. PLACE OF DEATH	
7. OCCUPATION		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. DATE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF JUDGE		17. SIGNATURE OF CLERK		18. SIGNATURE OF SHERIFF	
19. SIGNATURE OF DEPUTY SHERIFF		20. SIGNATURE OF CONSTABLE		21. SIGNATURE OF JURY	
22. SIGNATURE OF JURY		23. SIGNATURE OF JURY		24. SIGNATURE OF JURY	
25. SIGNATURE OF JURY		26. SIGNATURE OF JURY		27. SIGNATURE OF JURY	
28. SIGNATURE OF JURY		29. SIGNATURE OF JURY		30. SIGNATURE OF JURY	
31. SIGNATURE OF JURY		32. SIGNATURE OF JURY		33. SIGNATURE OF JURY	
34. SIGNATURE OF JURY		35. SIGNATURE OF JURY		36. SIGNATURE OF JURY	
37. SIGNATURE OF JURY		38. SIGNATURE OF JURY		39. SIGNATURE OF JURY	
40. SIGNATURE OF JURY		41. SIGNATURE OF JURY		42. SIGNATURE OF JURY	
43. SIGNATURE OF JURY		44. SIGNATURE OF JURY		45. SIGNATURE OF JURY	
46. SIGNATURE OF JURY		47. SIGNATURE OF JURY		48. SIGNATURE OF JURY	
49. SIGNATURE OF JURY		50. SIGNATURE OF JURY		51. SIGNATURE OF JURY	
52. SIGNATURE OF JURY		53. SIGNATURE OF JURY		54. SIGNATURE OF JURY	
55. SIGNATURE OF JURY		56. SIGNATURE OF JURY		57. SIGNATURE OF JURY	
58. SIGNATURE OF JURY		59. SIGNATURE OF JURY		60. SIGNATURE OF JURY	
61. SIGNATURE OF JURY		62. SIGNATURE OF JURY		63. SIGNATURE OF JURY	
64. SIGNATURE OF JURY		65. SIGNATURE OF JURY		66. SIGNATURE OF JURY	
67. SIGNATURE OF JURY		68. SIGNATURE OF JURY		69. SIGNATURE OF JURY	
70. SIGNATURE OF JURY		71. SIGNATURE OF JURY		72. SIGNATURE OF JURY	
73. SIGNATURE OF JURY		74. SIGNATURE OF JURY		75. SIGNATURE OF JURY	
76. SIGNATURE OF JURY		77. SIGNATURE OF JURY		78. SIGNATURE OF JURY	
79. SIGNATURE OF JURY		80. SIGNATURE OF JURY		81. SIGNATURE OF JURY	
82. SIGNATURE OF JURY		83. SIGNATURE OF JURY		84. SIGNATURE OF JURY	
85. SIGNATURE OF JURY		86. SIGNATURE OF JURY		87. SIGNATURE OF JURY	
88. SIGNATURE OF JURY		89. SIGNATURE OF JURY		90. SIGNATURE OF JURY	
91. SIGNATURE OF JURY		92. SIGNATURE OF JURY		93. SIGNATURE OF JURY	
94. SIGNATURE OF JURY		95. SIGNATURE OF JURY		96. SIGNATURE OF JURY	
97. SIGNATURE OF JURY		98. SIGNATURE OF JURY		99. SIGNATURE OF JURY	
100. SIGNATURE OF JURY		101. SIGNATURE OF JURY		102. SIGNATURE OF JURY	

BUREAU N. S.

MAR 17 1938

RECEIVED

3144

CERTIFICATE OF DEATH

Reg. Dist. No. 03124

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Westminster				c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. 6 Ogg Summitt				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Delilah Middle ---- Last Ogg				4. DATE OF DEATH Month March Day 24 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 20, 1889	
				9. AGE (In years last birthday) yrs. 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John L. Ogg				14. MOTHER'S MAIDEN NAME Solenia Green			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Miss Iova M. Ogg R. 6 Westminster, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Renal disease DUE TO Decompensation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension & arteriosclerosis DUE TO Chronic (c) Chronic INTERVAL BETWEEN ONSET AND DEATH 24 yrs 5 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan 4, 1957 to March 4, 1958 , that I last saw the deceased alive on March 7, 1958 , and that death occurred at 7:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W. G. Speicher, M.D. Westminster, Md. 3/24/58							
ACTUAL SIGNATURE				PHYSICIAN'S NAME (Type) W. G. Speicher, M.D. 135 E. Main St. Westminster, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-26-58		22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City, town, or county) (State) Smallwood Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R. Byers Westminster, Maryland				24a. REC'D BY REGISTRAR DATE MAR 26 '58		24b. REGISTRAR'S SIGNATURE W. G. Speicher	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES H. BURKE		MAY 1938	
AGE		SEX	
65		M	
RACE		RELIGION	
W		C	
BIRTH DATE		BIRTH PLACE	
MAY 1873		NEW YORK	
MARRIAGE DATE		MARRIAGE PLACE	
JAN 1900		NEW YORK	
DECEASED'S RESIDENCE		DECEASED'S OCCUPATION	
BALTIMORE, MD		LABORER	
CAUSE OF DEATH		IMMEDIATE CAUSE	
HEART DISEASE		CORONARY ARTERY DISEASE	
DISEASE		SYMPTOMS	
ANGINA PECTORIS		PAIN IN THE CHEST	
DURATION OF ILLNESS		DATE OF ONSET	
2 WEEKS		MAY 1938	
PLACE OF DEATH		DATE OF INTERMENT	
BALTIMORE, MD		MAY 1938	
NAME OF FUNERAL HOME		NAME OF MINISTER	
JAMES H. BURKE		JAMES H. BURKE	

BURKEAU V. S.

MAR 26 1938

RECEIVED

NAME OF DECEASED		DATE OF DEATH	
JAMES H. BURKE		MAY 1938	
AGE		SEX	
65		M	
RACE		RELIGION	
W		C	
BIRTH DATE		BIRTH PLACE	
MAY 1873		NEW YORK	
MARRIAGE DATE		MARRIAGE PLACE	
JAN 1900		NEW YORK	
DECEASED'S RESIDENCE		DECEASED'S OCCUPATION	
BALTIMORE, MD		LABORER	
CAUSE OF DEATH		IMMEDIATE CAUSE	
HEART DISEASE		CORONARY ARTERY DISEASE	
DISEASE		SYMPTOMS	
ANGINA PECTORIS		PAIN IN THE CHEST	
DURATION OF ILLNESS		DATE OF ONSET	
2 WEEKS		MAY 1938	
PLACE OF DEATH		DATE OF INTERMENT	
BALTIMORE, MD		MAY 1938	
NAME OF FUNERAL HOME		NAME OF MINISTER	
JAMES H. BURKE		JAMES H. BURKE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3145 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03125

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 13 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Susan Middle O'KEEFE Last O'KEEFE		4. DATE OF DEATH Month March Day 26 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Home-	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic rheumatic heart disease. 416x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) C.B.S. associated with disturbance of metabolism, growth or nutrition, with senile brain disease with psychotic reaction. Intertrochanteric fracture, left femur.			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 902.7	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II) Patient fell out of bed.		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh		DATE SIGNED 3/26/58	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/29/58	22c. NAME OF CEMETERY OR CREMATORY Emmanuel Cem.	22d. LOCATION (City, town, or county) (State) Seagoville Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Connelley		24a. REC'D BY REGISTRAR APR 2 '58	
ADDRESS Laurel Md.		24b. REGISTRAR'S SIGNATURE W. W. Connelley	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 16
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10-10-1939

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BUREAU V. 8

APR 2 1939

RECEIVED

CERTIFICATE OF DEATH

03126

Reg. Dist. No.

3146

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 19 yrs. 5 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Manchester	
3. NAME OF DECEASED (Type or print) First Millie Middle Kate Last Oursler		4. DATE OF DEATH Month March Day 5 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1870
9. AGE (In years last birthday) 87 yrs.		10. IF UNDER 1 YEAR: Months 87 Days 87 Hours 87 Min. 87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oliver Lippy		14. MOTHER'S MAIDEN NAME Margret Gross	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Springfield State Hospital Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction.			INTERVAL BETWEEN ONSET AND DEATH Mins. Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 22, 1938 , to March 5, 1958 , that I last saw the deceased alive on March 4, 1958 , and that death occurred at 6:35 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3/5/58			
ACTUAL SIGNATURE Gertrud Sonnenfeldt		M.D. Springfield State Hospital	
PHYSICIAN'S NAME (Type) Gertrud Sonnenfeldt, M.D.		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/7/58	22c. NAME OF CEMETERY OR CREMATORY Immanuel Lutheran Cem. Manchester Md.	22d. LOCATION (City, town, or county) (State) Manchester Md.
23. FUNERAL DIRECTOR'S SIGNATURE L. E. Myers, Jr.		ADDRESS Westminster Md.	
24a. REC'D BY REGISTRAR DATE MAR 10 '58		24b. REGISTRAR'S SIGNATURE W. L. Seach	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3147 CERTIFICATE OF DEATH

03127

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Carroll</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sykesville</u>		LENGTH OF STAY (in this place) <u>2 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Poulinville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Poulin Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Hicksbury Rd. 1, md.</u>			
3. NAME OF DECEASED (Type or Print) <u>John William Owens</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>March 29 19 58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 21, 1883</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>		11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George F. Owens</u>				14. MOTHER'S MAIDEN NAME <u>Mary J. Huffman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>W. J. Huffman</u> <u>Hicksbury Rd. 1, md.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
151X IMMEDIATE CAUSE (A) <u>PNEUMONIA, BRONCHIAL</u>						INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>CARCINOMA, STOMACH</u>						<u>10 MOS.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>1912</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>5/15/57</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma Stomach</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/24</u> 19 <u>57</u> , to <u>3/29</u> 19 <u>58</u> , that I last saw the deceased alive on <u>3/29</u> 19 <u>58</u> , and that death occurred at <u>5:00 P.</u> M, from the causes and on the date stated above. SIGNATURE <u>Morton E. Stroud</u> ADDRESS (Street, city, town, state) <u>48 Main Reston Md.</u> DATE SIGNED <u>3/30/58</u> M.D. <u>Reston Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-1-58</u>		NAME OF CEMETERY OR CREMATORY <u>Calvary Methodist</u>		LOCATION (City, town, or county) (State) <u>Hammer, Carroll Co. md.</u>	
24. REC'D BY REGISTRAR <u>APR 1 '58</u>		REGISTRAR'S SIGNATURE <u>W. J. Huffman</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Patricia H. Haight</u>		ADDRESS <u>Sykesville, md.</u>	

CERTIFICATE OF DEATH

Form 100-10

1. DECEASED'S NAME (Last, first, middle initial)

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. DATE OF DEATH

9. PLACE OF DEATH

10. CAUSE OF DEATH

11. MANNER OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF CHURCH OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CEMETERY

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BUREAU V. 1

APR 1 1958

RECEIVED

3148

CERTIFICATE OF DEATH

03128

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN TB 3 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				e. STREET ADDRESS 2308 E. Lafayette Ave.			
3. NAME OF DECEASED (Type or print) First Edith Mary Middle Arnold Last REID				4. DATE OF DEATH Month March Day 14 Year 19 58			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1899		9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store clerk		10b. KIND OF BUSINESS OR INDUSTRY Shoe and Millinery		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Arnold				14. MOTHER'S MAIDEN NAME Edith Reede			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unk -		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 491X (b) Arteriosclerotic heart disease DUE TO (c) Schizophrenic reaction, paranoid type. Cancer of left breast operated on prior to admission							INTERVAL BETWEEN ONSET AND DEATH days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic reaction, paranoid type. Cancer of left breast operated on prior to admission							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Springfield State Hospital		(County) Sykesville, Md.	(State) Md.
21. I certify that I attended the deceased from December 14, 19 57 , to March 14, 19 58 , that I last saw the deceased alive on March 14, 19 58 , and that death occurred at 1:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 3/14/58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-17-58	22c. NAME OF CEMETERY OR CREMATORY Springfield		22d. LOCATION (City, town, or county) (State) Sykesville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Arthur H. Haight				ADDRESS Sykesville, Md.		24a. REC'D BY REGISTRAR MAR 24 '58	24b. REGISTRAR'S SIGNATURE W. H. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED MARTIN		2. SEX M		3. AGE 30		4. DATE OF BIRTH 1910		5. PLACE OF BIRTH BALTIMORE	
6. OCCUPATION LABORER		7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE 1935		9. PLACE OF MARRIAGE BALTIMORE		10. NAME OF SPouse JOHN	
11. CAUSE OF DEATH HEART DISEASE		12. PLACE OF DEATH HOME		13. DATE OF DEATH 1940		14. TIME OF DEATH 10:00 AM		15. SIGNATURE OF PHYSICIAN J. H. SMITH	
16. SIGNATURE OF REGISTRAR J. H. SMITH		17. SIGNATURE OF WITNESS J. H. SMITH		18. SIGNATURE OF WITNESS J. H. SMITH		19. SIGNATURE OF WITNESS J. H. SMITH		20. SIGNATURE OF WITNESS J. H. SMITH	

RECEIVED
MAR 24 1958
BUREAU V. 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1 **CERTIFICATE OF DEATH**
Items 2 & 12, Film G227, 4/11/58 fcy

03129
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		d. STREET ADDRESS Unknown	
3. NAME OF DECEASED (Type or print) First Margaret Middle Rhinedollar Last Unknown		4. DATE OF DEATH Month 3 Day 21 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-12-1859-?
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		9b. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Shriner		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral bronchopneumonia with abscess formation DUE TO 526x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Bronchiectasis DUE TO (c) Abscess of left parotid gland INTERVAL BETWEEN ONSET AND DEATH days years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Brain Syndrome associated with senile brain disease with psychotics			
19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) reaction	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) reaction	
20c. TIME OF INJURY Month 19 Day 19 Year 1958 Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9-25 , 19 57 , to 3-21 , 19 58 , that I last saw the deceased alive on 3-21 , 19 58 , and that death occurred at 11:45 A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Gertrude M. Gross, M.D.		ADDRESS (Street, city or town, state) Springfield State Hospital	
PHYSICIAN'S NAME (Type) Gertrude M. Gross, M.D.		DATE SIGNED Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-24, 1958	
22c. NAME OF CEMETERY OR CREMATORY Hancock Church Cemetery		22d. LOCATION (City, town, or county) (State) near Leadbetter Md	
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Furst		24a. REGISTERED BY REGISTRAR 24-58	
ADDRESS Taneytown Md		24b. REGISTRAR'S SIGNATURE On...	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH	
9. DATE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS		16. SIGNATURE OF WITNESS	
17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS		19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS	
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RECEIVED
MAR 24 1950
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03130

3150

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 11 mos. 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 3121 Kentucky Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Ida Middle Pauline Last Klarner SADLER				4. DATE OF DEATH Month March Day 25 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1879	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (Companion)			10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Herman Klarner				14. MOTHER'S MAIDEN NAME Nanetta Auer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-16-5265		17. INFORMANT Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonitis 492x XXXX Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH Days Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month March Day 29 Year 1958 Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March 29, 1957 to March 25, 1958 , that I last saw the deceased alive on March 24, 1958 , and that death occurred at 4:45A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund Lusthaus, M.D.				ADDRESS (Street, city or town, state) Springfield State Hospital		DATE SIGNED 3/25/58	
PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D.				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-29-58		22c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street				24a. REC'D BY REGISTRAR MAR 28 '58		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 81

1953 02 MAR

RECEIVED

3151

CERTIFICATE OF DEATH

03131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>5 years 17 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. STREET ADDRESS <u>3925 Park Heights Ave.</u>							
3. NAME OF DECEASED (Type or print) First <u>Almerinda</u> Middle <u>Lucie</u> Last <u>Santilli</u>				4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>19 58</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6 - 8 - 1878</u>	
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Italy</u>			
12. CITIZEN OF WHAT COUNTRY? <u>Italy</u>							
13. FATHER'S NAME <u>Rocco Di Pietro</u>				14. MOTHER'S MAIDEN NAME <u>Esmiralda Rocco</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>212-07-6077A</u>			
17. INFORMANT <u>Springfield Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Asthma due to Arteriosclerotic heart dis-</u> <u>ease</u> DUE TO <u>420.0</u> years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ease</u> DUE TO (c) <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? <u>Chr. brain syndr. ass. with dist. of metabl. growth or nutrition, with senile brain disease with psych. reaction. Diabetes Mellitus</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>10 - 20 - 1954</u> , to <u>3 - 5 - 19 58</u> , that I last saw the deceased alive on <u>3 - 5 - 19 58</u> , and that death occurred at <u>12:40 AM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)				DATE SIGNED			
ACTUAL SIGNATURE <u>Edmund Lusthaus</u> M.D. <u>Springfield State Hospital</u>				<u>3-8-58</u>			
PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus M.D.</u>				<u>Sykesville, Maryland.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Com.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Pickner & Sons - Balto</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 11 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

— 106 —

6. 2

RECEIVED
MAR 11 1958
BUREAU V. S.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03132

Item 7, Film G227, 4/16/58

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. LENGTH OF STAY IN 1b 22 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights 16X-2		d. STREET ADDRESS 6032 Lee Place	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Arnold Middle Saunders Last Saunders		4. DATE OF DEATH Month March Day 27 Year 19 58	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 28, 1907
9. AGE (In years lost birthday) 51 yrs.		10. IF UNDER 1 YEAR Months 51 Days 16 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Ace Wrecking Co.	
11. BIRTHPLACE (State or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sam Saunders		14. MOTHER'S MAIDEN NAME Ophelia Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Arnold Saunders - Patient	
17. INFORMANT Arnold Saunders - Patient		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular insufficiency 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Far advanced bilateral pulmonary tuberculosis DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 5 , 19 58 , to March 27 , 19 58 , that I last saw the deceased alive on March 27 , 19 58 , and that death occurred at 11:15 A.M. , from the causes and on the date stated above. Edgars M. Maculans M.D. ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 3/27/58			
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) Edgars M. Maculans, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY H. G. M. Cemetery		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Frank A. Newell, Pittsville, Md.		24a. REC'D BY REGISTRAR DATE APR 1 '58	
24b. REGISTRAR'S SIGNATURE W. H. Smith			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 12

BUREAU V. S.

APR 1 1938

RECEIVED

3153

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Balto. City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 11 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 1427 McHenry St.			
3. NAME OF DECEASED (Type or print) First Neil Middle A. Last SCARBORO				4. DATE OF DEATH Month March Day 25 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 19 JUNE 1882	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months 7 Days 18 Hours 18 Min.		IF UNDER 24 HRS. Months 7 Days 18 Hours 18 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown CARPENTER				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) Unknown				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Unknown JAMES SCARBORO				14. MOTHER'S MAIDEN NAME Unknown HARRIE H			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Springfield Hospital Records			
17. INFORMANT Springfield Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Encephalopathy 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Cerebral arteriosclerosis DUE TO (c) Pulmonary tuberculosis, moderately advanced, active							INTERVAL BETWEEN ONSET AND DEATH Days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. associated with cerebral arteriosclerosis.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from March 14, 1958 , to March 25, 1958 , that I last saw the deceased alive on March 25, 1958 , and that death occurred at 2:55 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Julian Radd				ADDRESS (Street, city or town, state) Springfield State Hospital			
PHYSICIAN'S NAME (Type) Julian Radd, M.D.				DATE SIGNED 3/25/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 28 March 1958		22c. NAME OF CEMETERY OR CREMATORY MEADOW RIDGE CEM	
22d. LOCATION (City, town, or county) (State) BALTO Co Md							
23. FUNERAL DIRECTOR'S SIGNATURE North & P. M. Walters				ADDRESS 1427 McHenry St.		24a. REC'D BY REGISTRAR DATE MAR 28 '58	
24b. REGISTRAR'S SIGNATURE W. H. Leach							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35		4. RACE White		5. PLACE OF BIRTH Memphis, Tennessee	
6. DATE OF DEATH April 4, 1968		7. TIME OF DEATH 2:01 PM		8. PLACE OF DEATH Room 308, LBJ Library, Washington, D.C.		9. CAUSE OF DEATH Suicide by gunshot		10. MANNER OF DEATH Homicide	
11. SIGNATURE OF DECEASED (None)		12. SIGNATURE OF NEXT OF KIN None		13. SIGNATURE OF PHYSICIAN J. Edgar Hoover		14. SIGNATURE OF CORONER J. Edgar Hoover		15. SIGNATURE OF REGISTRAR J. Edgar Hoover	
16. NAME OF PHYSICIAN J. Edgar Hoover		17. ADDRESS OF PHYSICIAN Washington, D.C.		18. NAME OF CORONER J. Edgar Hoover		19. ADDRESS OF CORONER Washington, D.C.		20. NAME OF REGISTRAR J. Edgar Hoover	
21. ADDRESS OF DECEASED None		22. ADDRESS OF NEXT OF KIN None		23. ADDRESS OF PHYSICIAN Washington, D.C.		24. ADDRESS OF CORONER Washington, D.C.		25. ADDRESS OF REGISTRAR Washington, D.C.	

BUREAU Y. M.

APR 22 1968

RECEIVED

3154

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Carroll		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland Baltimore City 311	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 1 mo. 27 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital		e. STREET ADDRESS 1120 Old Northpoint Road	
3. NAME OF DECEASED (Type or print) First Joseph Middle Michael Last Schmeizl		4. DATE OF DEATH Month March Day 20 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-1879
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Bakery	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Schmeizl		14. MOTHER'S MAIDEN NAME Anna (unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 214-16-3290A	
17. INFORMANT Springfield State Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lung abscess, left lung 521X and DOE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 491X (b) Bronchopneumonia DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH days days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome associated with cerebral arteriosclerosis			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 21, 1958 , to March 20, 1958 , that I last saw the deceased alive on March 20, 1958 , and that death occurred at 10:45 P. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3/21/1958 ACTUAL SIGNATURE Agustin del Campo M.D. Agustin del Campo, M.D. PHYSICIAN'S NAME (Type) Sykesville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-24-1958	
22c. NAME OF CEMETERY OR CREMATORY Holy Redeemer		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Dahnowski		24a. REC'D BY REGISTRAR DATE 24 '58	
ADDRESS 1001 Dundalk Ave.		24b. REGISTRAR'S SIGNATURE Old	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

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VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES ALFRED JONES		2. SEX Male		3. AGE 35		4. PLACE OF BIRTH Baltimore, Maryland	
5. OCCUPATION Salesman		6. MARITAL STATUS Married		7. DATE OF DEATH March 24, 1953		8. PLACE OF DEATH Home	
9. CAUSE OF DEATH Myocardial Infarction		10. MANNER OF DEATH Natural		11. SIGNATURE OF PHYSICIAN J. Edgar Smith		12. SIGNATURE OF REGISTRAR John Doe	
13. DATE OF INTERMENT March 25, 1953		14. PLACE OF INTERMENT St. Mary's Cemetery		15. SIGNATURE OF MINISTER Rev. W. B. Jones		16. SIGNATURE OF WITNESSES John Doe, Jane Doe	
17. SIGNATURE OF DECEASED James A. Jones		18. SIGNATURE OF NEXT OF KIN Mrs. J. A. Jones		19. SIGNATURE OF REGISTRAR John Doe		20. SIGNATURE OF PHYSICIAN J. Edgar Smith	

RECEIVED
MAR 24 1953
BUREAU Y. S.

3100

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>33 CARROLL ST.</u>		d. STREET ADDRESS <u>1 31 CARROLL ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE MAX SCHWINN</u>		4. DATE OF DEATH Month Day Year <u>MARCH 2 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 22 1887</u>
9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>70</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>CARROLL CO. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACOB H. BEMILLER</u>		14. MOTHER'S MAIDEN NAME <u>MANDELLIA DUTTROW</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>MRS. EMMA RINAMAN</u>		Address <u>33 CARROLL ST WESTMINSTER Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PNEUMONIA LOBAR. - (CLEARED) WEEK</u> (c) <u>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</u> INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB 6</u> , 19 <u>58</u> , to <u>MARCH 2</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>FEB. 26</u> , 19 <u>58</u> , and that death occurred at <u>8:05 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Daniel I Welliver</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>19 N. Church St 3-2-58</u>	
PHYSICIAN'S NAME (Type) <u>DANIEL I. WELLIVER</u>		<u>Westminster Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>3/5/58</u>	<u>MEADOW BRANCH CEM. RURAL WESTMINSTER Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 4 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Deel</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3155

CERTIFICATE OF DEATH

Reg. Dist. No.

03138

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>COUNTY HOME</u>		d. STREET ADDRESS <u>WATFIELDSBURG</u>	
3. NAME OF DECEASED (Type or print) <u>LEROT SELLMAN</u>		4. DATE OF DEATH <u>MAR. 12 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUN 15 1889</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>VACHEL SELLMAN</u>		14. MOTHER'S MAIDEN NAME <u>ADELAIDE ARNOLD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>CLYDE SELLMAN</u>		Address <u>WATNESBORO, PA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cbma</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes</u> DUE TO (c) <u>over eating</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>X</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>X</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>X</u> 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1945</u> to <u>3-12-1958</u> , that I last saw the deceased alive on <u>3-12-1958</u> , and that death occurred at <u>9P</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. C. Stone</u>		DATE SIGNED <u>3-12-1958</u>	
PHYSICIAN'S NAME (Type) <u>W. C. Stone</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>3-15-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>STONE CHAPEL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WATFIELDSBURG, MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>David C. Bankard</u>		ADDRESS <u>Westminster, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 18 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Alfred Smith</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, occupation, cause of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. S.

MAR 18 1958

RECEIVED

3156

CERTIFICATE OF DEATH

03136

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SYKESVILLE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE, RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SUNSET DRIVE		d. STREET ADDRESS SUNSET DRIVE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last OTIS WORTHINGTON Shipley		4. DATE OF DEATH Month Day Year MAR. 12 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-12-1898
9. AGE (In years last birthday) 69 7/8 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POLICE OFFICER		10b. KIND OF BUSINESS OR INDUSTRY Baltimore Police	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME THOS. SHIPLEY		14. MOTHER'S MAIDEN NAME MARY MARCELA CROSS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-28567L	
17. INFORMANT WIFE		Address SYKESVILLE, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC CARCINOMA 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHIOGENIC CARCINOMA DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 YR. 2 YRS
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from SEPT , 19 57 , to MAR , 19 58 , that I last saw the deceased alive on 3-11 , 19 58 , and that death occurred at 11:20AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED LIBERTY RD. SYKESVILLE, MARYLAND			
ACTUAL SIGNATURE Norman V. Houck		M.D.	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 3/15/1958	22c. NAME OF CEMETERY OR CREMATORY West Aline	22d. LOCATION (City, town, or county) (State) Randallstown Md
23. FUNERAL DIRECTOR'S SIGNATURE Lois Byers		ADDRESS 5205 Pk Highway	24a. REC'D BY REGISTRAR MAR 14 '58
		24b. REGISTRAR'S SIGNATURE Robert	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO PRESS

1958 7.4 1143

RECEIVED

3157

CERTIFICATE OF DEATH

03137

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>			
c. LENGTH OF STAY IN 1b <u>10 yrs</u>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MISSOURI</u> Middle <u>L-SHUMAN</u> Last <u></u>				4. DATE OF DEATH Month <u>March</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>♂</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 26 - 1866</u>	9. AGE (In years last birthday) <u>91</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>Mrs Herbert Smith - Manchester, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Fractured Hip</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>(a) Anteromedian Heart Disease</u> (c) <u>5 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>904.9 Fractured hip - 2 months</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>48</u> , to <u>March 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>March 11</u> , 19 <u>58</u> , and that death occurred at <u>12:05 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.H. Foard</u>				DATE SIGNED <u>3/13/58</u>			
PHYSICIAN'S NAME (Type) <u>W. H. FOARD M.D.</u>				ADDRESS (Street, city or town, state) <u>Manchester, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 15, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw A Tipton</u>				24a. REC'D BY REGISTRAR <u>W. Leach</u>			
ADDRESS <u>Hampstead Md</u>				24b. REGISTRAR'S SIGNATURE <u>W. Leach</u>			
DATE <u>MAR 17 '58</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3158

CERTIFICATE OF DEATH

Reg. Dist. No. 03139

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE SAMUEL SMITH</u>		4. DATE OF DEATH Month Day Year <u>MAR 28 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 20 - 1894</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>CHARLES W SMITH</u>	
14. MOTHER'S MAIDEN NAME <u>LUCERTIA TRAIL</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>215-36-8116</u>		17. INFORMANT Address <u>LELA D SMITH UNION BRIDGE RURAL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Basal Neurotoma</u> DUE TO (b) <u>Verbal argument with</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>high temper</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. ft. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-28-1958</u> to <u>3-28-1958</u> , that I last saw the deceased alive on <u>3-28-1958</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>J. H. Legg</u> M.D.		ADDRESS (Street, city or town, state) <u>Union Bridge MD</u>	
DATE SIGNED <u>3-28-58</u>		PHYSICIAN'S NAME (Type) <u>T. H. LIEGG MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/31/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVET</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hartzler & Sons</u>		ADDRESS <u>Union Bridge Md</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Hartzler</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

31 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03140

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN 1b <u>30 YRS.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER 27</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>19 WEBSTER ST.</u>			d. STREET ADDRESS <u>19 WEBSTER ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ALICE SNYDER</u>			4. DATE OF DEATH Month Day Year <u>MARCH 26 1958</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 13, 1879</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>	
13. FATHER'S NAME <u>EMORY SHAFER</u>			14. MOTHER'S MAIDEN NAME <u>MARTHA ELLEN SHAFER</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>19 WEBSTER ST. WESTMINSTER MD.</u> <u>MR EDGAR LEISTER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>MD.</u>	
20f. (City or town) <u>MD.</u>		20g. (County) <u>MD.</u>		20h. (State) <u>MD.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>James J. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>MAR 26/58</u>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-29-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEM.</u>	
22d. LOCATION (City, town, or county) <u>MD.</u>		22e. (State) <u>MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>David A. Bankard Westminster, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 31 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
31 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED
SEX

AGE

DATE OF DEATH

PLACE OF DEATH
CITY
COUNTY
STATE

CAUSE OF DEATH
IMMEDIATE
INTERMEDIATE
FINAL

THE CAUSE OF DEATH IS AS FOLLOWS

DATE OF DEATH

THE DECEASED WAS FOUND BY

THE DECEASED WAS FOUND BY

THE DECEASED WAS FOUND BY

DATE OF DEATH

THE DECEASED WAS FOUND BY

THE DECEASED WAS FOUND BY

DATE OF DEATH

THE DECEASED WAS FOUND BY

DATE OF DEATH

THE DECEASED WAS FOUND BY

DATE OF DEATH

BUREAU V. S.

MAR 31 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03141

3159

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>		c. LENGTH OF STAY IN 1b <u>8 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>X SYKESVILLE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH CATHERINE STEM</u>		4. DATE OF DEATH Month Day Year <u>MARCH 28 1958</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/1/184</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARROLL Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN W. WILLIAMS</u>		14. MOTHER'S MAIDEN NAME <u>MARY A. BARNES</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>L. Guy Stem.</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis,</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis heart disease</u> DUE TO (c) <u>myocardial infarction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1954</u> <u>28 March 58</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1954</u> , 19 <u>58</u> , to <u>28 March, 1958</u> , that I last saw the deceased alive on <u>28 March, 1958</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u>		DATE SIGNED <u>28 March 58</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-30-1958</u>	
22c. NAME OF CEMETERY OR CREMATOR <u>Ebenezer</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jim Wartz</u>		ADDRESS <u>Wmfield, Md.</u>	
24a. REC'D BY REGISTRAR <u>APR 1 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>	

UREAU V. S.

APR 1 1958

RECEIVED

3160

CERTIFICATE OF DEATH

Reg. Dist. No. **03142**

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
c. LENGTH OF STAY IN 1b 1 yr. 3mths. 28 days				3V01-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springfield State Hospital				d. STREET ADDRESS 7407 Glenoak Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Renno Last STUCKRATH				4. DATE OF DEATH Month March Day 26 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 17, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Francis Warns				14. MOTHER'S MAIDEN NAME Elizabeth Davidson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -		17. INFORMANT Address Springfield State Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS associated with senile brain disease, with psychotic reaction							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 28, 1956 , to March 26, 1958 , that I last saw the deceased alive on March 26, 1958 , and that death occurred at 2:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3-26-58 ACTUAL SIGNATURE Edmund Lusthaus M.D. PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) 3-29-58		22b. DATE THEREOF 3-29-58		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) BALTO MD	
23. FUNERAL DIRECTOR'S SIGNATURE Edward J. Kuck				24a. REC'D BY REGISTRAR 2-8-58		24b. REGISTRAR'S SIGNATURE On! will	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. CAUSE OF DEATH		10. PLACE OF DEATH		11. TIME OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
17. PLACE OF INTERMENT		18. TIME OF INTERMENT		19. SIGNATURE OF INTERMENT OFFICIAL		20. SIGNATURE OF DECEASED		21. SIGNATURE OF NEXT OF KIN		22. SIGNATURE OF WITNESS		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF REGISTRAR	

RECEIVED
 MAR 28 1938
 BUREAU V. A.

3161

CERTIFICATE OF DEATH

Reg. Dist. No. 03143

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville (Rural)</u>				c. LENGTH OF STAY IN 1b <u>23 yr. 3 mo. 19 da.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>Midland</u>			
3. NAME OF DECEASED (Type or print) First <u>Alberta</u> Middle <u>Tighe</u> Last <u>Tighe</u>				4. DATE OF DEATH Month <u>March</u> Day <u>29</u> Year <u>19 58</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>December 9, 1898</u>	
9. AGE (In years lost birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Worker</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Aluminum Plant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas Tighe</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Steveson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT Address <u>Springfield State Hospital Record</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO <u>Hypertension involving the heart (coronary artery)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u> </u> DUE TO <u> </u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Dementia Praecox, catatonic type.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>58</u>				20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 1</u> , 19 <u>50</u> , to <u>March 29</u> , 19 <u>58</u> , that I lost saw the deceased olive on <u>March 29</u> , 19 <u>58</u> , and that death occurred at <u>4</u> p. m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Gertrud Sonnenfeldt</u> M.D. <u>Springfield State Hospital</u> <u>3/31/58</u>							
ACTUAL SIGNATURE <u>Gertrud Sonnenfeldt</u>				PHYSICIAN'S NAME (Type) <u>Gertrud Sonnenfeldt, M.D.</u> <u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4-2-58</u>		<u>New Cathedral</u>		<u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>				24a. REC'D BY REGISTRAR DATE <u>APR 3 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Beach</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH



BUREAU V. E.

APR 3 1958

RECEIVED

3162

CERTIFICATE OF DEATH

Reg. Dist. No.

03144

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>427 BALTIMORE, BLVD.</u>		d. STREET ADDRESS <u>427 BALTIMORE, MD.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH LEO TRACY</u>		4. DATE OF DEATH Month Day Year <u>MARCH 12 1958</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 19, 1895</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED GAURD, PENITENTARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>JOHNSTONE, Rhode Is.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLARENCE TRACY</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>214-26-5100</u>	
17. INFORMANT <u>J. L. Tracy Westminster, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> DUE TO (c) <u>420.1</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 MIN</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>DEC 1957</u> , to <u>MAR 12, 1958</u> , that I last saw the deceased alive on <u>MAR 10, 1958</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James J. Marsh</u>		ADDRESS (Street, city or town, state) <u>105 E MAIN ST WESTMINSTER MD</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T. MARSH</u>		DATE SIGNED <u>5/13/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>MARCH 14, 58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NATIONAL CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md.</u>		24a. REC'D BY REGISTRAR <u>MAR 14 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Paul Smith</u>

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. BIRTH DATE		6. BIRTH PLACE		7. BIRTH COUNTRY		8. BIRTH STATE		9. BIRTH CITY		10. BIRTH COUNTY		11. BIRTH DISTRICT		12. BIRTH TOWNSHIP		13. BIRTH VILLAGE		14. BIRTH CENSUS TRACT		15. BIRTH BLOCK		16. BIRTH HOUSE NUMBER		17. BIRTH STREET		18. BIRTH CITY		19. BIRTH COUNTY		20. BIRTH STATE		21. BIRTH COUNTRY		22. BIRTH DATE		23. BIRTH TIME		24. BIRTH PLACE		25. BIRTH COUNTRY		26. BIRTH STATE		27. BIRTH CITY		28. BIRTH COUNTY		29. BIRTH DISTRICT		30. BIRTH TOWNSHIP		31. BIRTH VILLAGE		32. BIRTH CENSUS TRACT		33. BIRTH BLOCK		34. BIRTH HOUSE NUMBER		35. BIRTH STREET		36. BIRTH CITY		37. BIRTH COUNTY		38. BIRTH STATE		39. BIRTH COUNTRY		40. BIRTH DATE		41. BIRTH TIME		42. BIRTH PLACE		43. BIRTH COUNTRY		44. BIRTH STATE		45. BIRTH CITY		46. BIRTH COUNTY		47. BIRTH DISTRICT		48. BIRTH TOWNSHIP		49. BIRTH VILLAGE		50. BIRTH CENSUS TRACT		51. BIRTH BLOCK		52. BIRTH HOUSE NUMBER		53. BIRTH STREET		54. BIRTH CITY		55. BIRTH COUNTY		56. BIRTH STATE		57. BIRTH COUNTRY		58. BIRTH DATE		59. BIRTH TIME		60. BIRTH PLACE		61. BIRTH COUNTRY		62. BIRTH STATE		63. BIRTH CITY		64. BIRTH COUNTY		65. BIRTH DISTRICT		66. BIRTH TOWNSHIP		67. BIRTH VILLAGE		68. BIRTH CENSUS TRACT		69. BIRTH BLOCK		70. BIRTH HOUSE NUMBER		71. BIRTH STREET		72. BIRTH CITY		73. BIRTH COUNTY		74. BIRTH STATE		75. BIRTH COUNTRY		76. BIRTH DATE		77. BIRTH TIME		78. BIRTH PLACE		79. BIRTH COUNTRY		80. BIRTH STATE		81. BIRTH CITY		82. BIRTH COUNTY		83. BIRTH DISTRICT		84. BIRTH TOWNSHIP		85. BIRTH VILLAGE		86. BIRTH CENSUS TRACT		87. BIRTH BLOCK		88. BIRTH HOUSE NUMBER		89. BIRTH STREET		90. BIRTH CITY		91. BIRTH COUNTY		92. BIRTH STATE		93. BIRTH COUNTRY		94. BIRTH DATE		95. BIRTH TIME		96. BIRTH PLACE		97. BIRTH COUNTRY		98. BIRTH STATE		99. BIRTH CITY		100. BIRTH COUNTY		101. BIRTH DISTRICT		102. BIRTH TOWNSHIP		103. BIRTH VILLAGE		104. BIRTH CENSUS TRACT		105. BIRTH BLOCK		106. BIRTH HOUSE NUMBER		107. BIRTH STREET		108. BIRTH CITY		109. BIRTH COUNTY		110. BIRTH STATE		111. BIRTH COUNTRY		112. BIRTH DATE		113. BIRTH TIME		114. BIRTH PLACE		115. BIRTH COUNTRY		116. BIRTH STATE		117. BIRTH CITY		118. BIRTH COUNTY		119. BIRTH DISTRICT		120. BIRTH TOWNSHIP		121. BIRTH VILLAGE		122. BIRTH CENSUS TRACT		123. BIRTH BLOCK		124. BIRTH HOUSE NUMBER		125. BIRTH STREET		126. BIRTH CITY		127. BIRTH COUNTY		128. BIRTH STATE		129. BIRTH COUNTRY		130. BIRTH DATE		131. BIRTH TIME		132. BIRTH PLACE		133. BIRTH COUNTRY		134. BIRTH STATE		135. BIRTH CITY		136. BIRTH COUNTY		137. BIRTH DISTRICT		138. BIRTH TOWNSHIP		139. BIRTH VILLAGE		140. BIRTH CENSUS TRACT		141. BIRTH BLOCK		142. BIRTH HOUSE NUMBER		143. BIRTH STREET		144. BIRTH CITY		145. BIRTH COUNTY		146. BIRTH STATE		147. BIRTH COUNTRY		148. BIRTH DATE		149. BIRTH TIME		150. BIRTH PLACE		151. BIRTH COUNTRY		152. BIRTH STATE		153. BIRTH CITY		154. BIRTH COUNTY		155. BIRTH DISTRICT		156. BIRTH TOWNSHIP		157. BIRTH VILLAGE		158. BIRTH CENSUS TRACT		159. BIRTH BLOCK		160. BIRTH HOUSE NUMBER		161. BIRTH STREET		162. BIRTH CITY		163. BIRTH COUNTY		164. BIRTH STATE		165. BIRTH COUNTRY		166. BIRTH DATE		167. BIRTH TIME		168. BIRTH PLACE		169. BIRTH COUNTRY		170. BIRTH STATE		171. BIRTH CITY		172. BIRTH COUNTY		173. BIRTH DISTRICT		174. BIRTH TOWNSHIP		175. BIRTH VILLAGE		176. BIRTH CENSUS TRACT		177. BIRTH BLOCK		178. BIRTH HOUSE NUMBER		179. BIRTH STREET		180. BIRTH CITY		181. BIRTH COUNTY		182. BIRTH STATE		183. BIRTH COUNTRY		184. BIRTH DATE		185. BIRTH TIME		186. BIRTH PLACE		187. BIRTH COUNTRY		188. BIRTH STATE		189. BIRTH CITY		190. BIRTH COUNTY		191. BIRTH DISTRICT		192. BIRTH TOWNSHIP		193. BIRTH VILLAGE		194. BIRTH CENSUS TRACT		195. BIRTH BLOCK		196. BIRTH HOUSE NUMBER		197. BIRTH STREET		198. BIRTH CITY		199. BIRTH COUNTY		200. BIRTH STATE		201. BIRTH COUNTRY		202. BIRTH DATE		203. BIRTH TIME		204. BIRTH PLACE		205. BIRTH COUNTRY		206. BIRTH STATE		207. BIRTH CITY		208. BIRTH COUNTY		209. BIRTH DISTRICT		210. BIRTH TOWNSHIP		211. BIRTH VILLAGE		212. BIRTH CENSUS TRACT		213. BIRTH BLOCK		214. BIRTH HOUSE NUMBER		215. BIRTH STREET		216. BIRTH CITY		217. BIRTH COUNTY		218. BIRTH STATE		219. BIRTH COUNTRY		220. BIRTH DATE		221. BIRTH TIME		222. BIRTH PLACE		223. BIRTH COUNTRY		224. BIRTH STATE		225. BIRTH CITY		226. BIRTH COUNTY		227. BIRTH DISTRICT		228. BIRTH TOWNSHIP		229. BIRTH VILLAGE		230. BIRTH CENSUS TRACT		231. BIRTH BLOCK		232. BIRTH HOUSE NUMBER		233. BIRTH STREET		234. BIRTH CITY		235. BIRTH COUNTY		236. BIRTH STATE		237. BIRTH COUNTRY		238. BIRTH DATE		239. BIRTH TIME		240. BIRTH PLACE		241. BIRTH COUNTRY		242. BIRTH STATE		243. BIRTH CITY		244. BIRTH COUNTY		245. BIRTH DISTRICT		246. BIRTH TOWNSHIP		247. BIRTH VILLAGE		248. BIRTH CENSUS TRACT		249. BIRTH BLOCK		250. BIRTH HOUSE NUMBER		251. BIRTH STREET		252. BIRTH CITY		253. BIRTH COUNTY		254. BIRTH STATE		255. BIRTH COUNTRY		256. BIRTH DATE		257. BIRTH TIME		258. BIRTH PLACE		259. BIRTH COUNTRY		260. BIRTH STATE		261. BIRTH CITY		262. BIRTH COUNTY		263. BIRTH DISTRICT		264. BIRTH TOWNSHIP		265. BIRTH VILLAGE		266. BIRTH CENSUS TRACT		267. BIRTH BLOCK		268. BIRTH HOUSE NUMBER		269. BIRTH STREET		270. BIRTH CITY		271. BIRTH COUNTY		272. BIRTH STATE		273. BIRTH COUNTRY		274. BIRTH DATE		275. BIRTH TIME		276. BIRTH PLACE		277. BIRTH COUNTRY		278. BIRTH STATE		279. BIRTH CITY		280. BIRTH COUNTY		281. BIRTH DISTRICT		282. BIRTH TOWNSHIP		283. BIRTH VILLAGE		284. BIRTH CENSUS TRACT		285. BIRTH BLOCK		286. BIRTH HOUSE NUMBER		287. BIRTH STREET		288. BIRTH CITY		289. BIRTH COUNTY		290. BIRTH STATE		291. BIRTH COUNTRY		292. BIRTH DATE		293. BIRTH TIME		294. BIRTH PLACE		295. BIRTH COUNTRY		296. BIRTH STATE		297. BIRTH CITY		298. BIRTH COUNTY		299. BIRTH DISTRICT		300. BIRTH TOWNSHIP		301. BIRTH VILLAGE		302. BIRTH CENSUS TRACT		303. BIRTH BLOCK		304. BIRTH HOUSE NUMBER		305. BIRTH STREET		306. BIRTH CITY		307. BIRTH COUNTY		308. BIRTH STATE		309. BIRTH COUNTRY		310. BIRTH DATE		311. BIRTH TIME		312. BIRTH PLACE		313. BIRTH COUNTRY		314. BIRTH STATE		315. BIRTH CITY		316. BIRTH COUNTY		317. BIRTH DISTRICT		318. BIRTH TOWNSHIP		319. BIRTH VILLAGE		320. BIRTH CENSUS TRACT		321. BIRTH BLOCK		322. BIRTH HOUSE NUMBER		323. BIRTH STREET		324. BIRTH CITY		325. BIRTH COUNTY		326. BIRTH STATE		327. BIRTH COUNTRY		328. BIRTH DATE		329. BIRTH TIME		330. BIRTH PLACE		331. BIRTH COUNTRY		332. BIRTH STATE		333. BIRTH CITY		334. BIRTH COUNTY		335. BIRTH DISTRICT		336. BIRTH TOWNSHIP		337. BIRTH VILLAGE		338. BIRTH CENSUS TRACT		339. BIRTH BLOCK		340. BIRTH HOUSE NUMBER		341. BIRTH STREET		342. BIRTH CITY		343. BIRTH COUNTY		344. BIRTH STATE		345. BIRTH COUNTRY		346. BIRTH DATE		347. BIRTH TIME		348. BIRTH PLACE		349. BIRTH COUNTRY		350. BIRTH STATE		351. BIRTH CITY		352. BIRTH COUNTY		353. BIRTH DISTRICT		354. BIRTH TOWNSHIP		355. BIRTH VILLAGE		356. BIRTH CENSUS TRACT		357. BIRTH BLOCK		358. BIRTH HOUSE NUMBER		359. BIRTH STREET		360. BIRTH CITY		361. BIRTH COUNTY		362. BIRTH STATE		363. BIRTH COUNTRY		364. BIRTH DATE		365. BIRTH TIME		366. BIRTH PLACE		367. BIRTH COUNTRY		368. BIRTH STATE		369. BIRTH CITY		370. BIRTH COUNTY		371. BIRTH DISTRICT		372. BIRTH TOWNSHIP		373. BIRTH VILLAGE		374. BIRTH CENSUS TRACT		375. BIRTH BLOCK		376. BIRTH HOUSE NUMBER		377. BIRTH STREET		378. BIRTH CITY		379. BIRTH COUNTY		380. BIRTH STATE		381. BIRTH COUNTRY		382. BIRTH DATE		383. BIRTH TIME		384. BIRTH PLACE		385. BIRTH COUNTRY		386. BIRTH STATE		387. BIRTH CITY		388. BIRTH COUNTY		389. BIRTH DISTRICT		390. BIRTH TOWNSHIP		391. BIRTH VILLAGE		392. BIRTH CENSUS TRACT		393. BIRTH BLOCK		394. BIRTH HOUSE NUMBER		395. BIRTH STREET		396. BIRTH CITY		397. BIRTH COUNTY		398. BIRTH STATE		399. BIRTH COUNTRY		400. BIRTH DATE		401. BIRTH TIME		402. BIRTH PLACE		403. BIRTH COUNTRY		404. BIRTH STATE		405. BIRTH CITY		406. BIRTH COUNTY		407. BIRTH DISTRICT		408. BIRTH TOWNSHIP		409. BIRTH VILLAGE		410. BIRTH CENSUS TRACT		411. BIRTH BLOCK		412. BIRTH HOUSE NUMBER		413. BIRTH STREET		414. BIRTH CITY		415. BIRTH COUNTY		416. BIRTH STATE		417. BIRTH COUNTRY		418. BIRTH DATE		419. BIRTH TIME		420. BIRTH PLACE		421. BIRTH COUNTRY		422. BIRTH STATE		423. BIRTH CITY		424. BIRTH COUNTY		425. BIRTH DISTRICT		426. BIRTH TOWNSHIP		427. BIRTH VILLAGE		428. BIRTH CENSUS TRACT		429. BIRTH BLOCK		430. BIRTH HOUSE NUMBER		431. BIRTH STREET		432. BIRTH CITY		433. BIRTH COUNTY		434. BIRTH STATE		435. BIRTH COUNTRY		436. BIRTH DATE		437. BIRTH TIME		438. BIRTH PLACE		439. BIRTH COUNTRY		440. BIRTH STATE		441. BIRTH CITY		442. BIRTH COUNTY		443. BIRTH DISTRICT		444. BIRTH TOWNSHIP		445. BIRTH VILLAGE		446. BIRTH CENSUS TRACT		447. BIRTH BLOCK		448. BIRTH HOUSE NUMBER		449. BIRTH STREET		450. BIRTH CITY		451. BIRTH COUNTY		452. BIRTH STATE		453. BIRTH COUNTRY		454. BIRTH DATE		455. BIRTH TIME		456. BIRTH PLACE		457. BIRTH COUNTRY		458. BIRTH STATE		459. BIRTH CITY		460. BIRTH COUNTY		461. BIRTH DISTRICT		462. BIRTH TOWNSHIP		463. BIRTH VILLAGE		464. BIRTH CENSUS TRACT		465. BIRTH BLOCK		466. BIRTH HOUSE NUMBER		467. BIRTH STREET		468. BIRTH CITY		469. BIRTH COUNTY		470. BIRTH STATE		471. BIRTH COUNTRY		472. BIRTH DATE		473. BIRTH TIME		474. BIRTH PLACE		475. BIRTH COUNTRY		476. BIRTH STATE		477. BIRTH CITY		478. BIRTH COUNTY		479. BIRTH DISTRICT		480. BIRTH TOWNSHIP		481. BIRTH VILLAGE		482. BIRTH CENSUS TRACT		483. BIRTH BLOCK		484. BIRTH HOUSE NUMBER		485. BIRTH STREET		486. BIRTH CITY		487. BIRTH COUNTY		488. BIRTH STATE		489. BIRTH COUNTRY		490. BIRTH DATE		491. BIRTH TIME		492. BIRTH PLACE		493. BIRTH COUNTRY		494. BIRTH STATE		495. BIRTH CITY		496. BIRTH COUNTY		497. BIRTH DISTRICT		498. BIRTH TOWNSHIP		499. BIRTH VILLAGE		500. BIRTH CENSUS TRACT		501. BIRTH BLOCK		502. BIRTH HOUSE NUMBER		503. BIRTH STREET		504. BIRTH CITY		505. BIRTH COUNTY		506. BIRTH STATE		507. BIRTH COUNTRY		508. BIRTH DATE		509. BIRTH TIME		510. BIRTH PLACE		511. BIRTH COUNTRY		512. BIRTH STATE		513. BIRTH CITY		514. BIRTH COUNTY		515. BIRTH DISTRICT		516. BIRTH TOWNSHIP		517. BIRTH VILLAGE		518. BIRTH CENSUS TRACT		519. BIRTH BLOCK		520. BIRTH HOUSE NUMBER		521. BIRTH STREET		522. BIRTH CITY		523. BIRTH COUNTY		524. BIRTH STATE		525. BIRTH COUNTRY		526. BIRTH DATE		527. BIRTH TIME		528. BIRTH PLACE		529. BIRTH COUNTRY		530. BIRTH STATE		531. BIRTH CITY		532. BIRTH COUNTY		533. BIRTH DISTRICT		534. BIRTH TOWNSHIP		535. BIRTH VILLAGE		536. BIRTH CENSUS TRACT		537. BIRTH BLOCK		538. BIRTH HOUSE NUMBER		539. BIRTH STREET		540. BIRTH CITY		541. BIRTH COUNTY		542. BIRTH STATE		543. BIRTH COUNTRY		544. BIRTH DATE		545. BIRTH TIME		546. BIRTH PLACE		547. BIRTH COUNTRY		548. BIRTH STATE		549. BIRTH CITY		550. BIRTH COUNTY		551. BIRTH DISTRICT		552. BIRTH TOWNSHIP		553. BIRTH VILLAGE		554. BIRTH CENSUS TRACT		555. BIRTH BLOCK		556. BIRTH HOUSE NUMBER		557. BIRTH STREET		558. BIRTH CITY		559. BIRTH COUNTY		560. BIRTH STATE		561. BIRTH COUNTRY		562. BIRTH DATE		563. BIRTH TIME		564. BIRTH PLACE		565. BIRTH COUNTRY		566. BIRTH STATE		567. BIRTH CITY		568. BIRTH COUNTY		569. BIRTH DISTRICT		570. BIRTH TOWNSHIP		571. BIRTH VILLAGE		572. BIRTH CENSUS TRACT		573. BIRTH BLOCK		574. BIRTH HOUSE NUMBER		575. BIRTH STREET		576. BIRTH CITY		577. BIRTH COUNTY		578. BIRTH STATE		579. BIRTH COUNTRY		580. BIRTH DATE		581. BIRTH TIME		582. BIRTH PLACE		583. BIRTH COUNTRY		584. BIRTH STATE		585. BIRTH CITY		586. BIRTH COUNTY		587. BIRTH DISTRICT		588. BIRTH TOWNSHIP		589. BIRTH VILLAGE		590. BIRTH CENSUS TRACT		591. BIRTH BLOCK		592. BIRTH HOUSE NUMBER		593. BIRTH STREET		594. BIRTH CITY		595. BIRTH COUNTY		596. BIRTH STATE		597. BIRTH COUNTRY		598. BIRTH DATE		599. BIRTH TIME		600. BIRTH PLACE		601. BIRTH COUNTRY		602. BIRTH STATE		603. BIRTH CITY		604. BIRTH COUNTY		605. BIRTH DISTRICT		606. BIRTH TOWNSHIP		607. BIRTH VILLAGE		608. BIRTH CENSUS TRACT		609. BIRTH BLOCK		610. BIRTH HOUSE NUMBER		611. BIRTH STREET		612. BIRTH CITY		613. BIRTH COUNTY		614. BIRTH STATE		615. BIRTH COUNTRY		616. BIRTH DATE		617. BIRTH TIME		618. BIRTH PLACE		619. BIRTH COUNTRY		620. BIRTH STATE		621. BIRTH CITY		622. BIRTH COUNTY		623. BIRTH DISTRICT		624. BIRTH TOWNSHIP		625. BIRTH VILLAGE		626. BIRTH CENSUS TRACT		627. BIRTH BLOCK		628. BIRTH HOUSE NUMBER		629. BIRTH STREET		630. BIRTH CITY		631. BIRTH COUNTY		632. BIRTH STATE		633. BIRTH COUNTRY		634. BIRTH DATE		635. BIRTH TIME		636. BIRTH PLACE		637. BIRTH COUNTRY		638. BIRTH STATE		639. BIRTH CITY		640. BIRTH COUNTY		641. BIRTH DISTRICT		642. BIRTH TOWNSHIP		643. BIRTH VILLAGE		644. BIRTH CENSUS TRACT		645. BIRTH BLOCK		646. BIRTH HOUSE NUMBER		647. BIRTH STREET		648. BIRTH CITY		649. BIRTH COUNTY		650. BIRTH STATE		651. BIRTH COUNTRY		652. BIRTH DATE		653. BIRTH TIME		654. BIRTH PLACE		655. BIRTH COUNTRY		656. BIRTH STATE		657. BIRTH CITY		658. BIRTH COUNTY		659. BIRTH DISTRICT		660. BIRTH TOWNSHIP		661. BIRTH VILLAGE		662. BIRTH CENSUS TRACT		663. BIRTH BLOCK		664. BIRTH HOUSE NUMBER		665. BIRTH STREET		666. BIRTH CITY		667. BIRTH COUNTY		668. BIRTH STATE		669. BIRTH COUNTRY		670. BIRTH DATE		671. BIRTH TIME		672. BIRTH PLACE		673. BIRTH COUNTRY		674. BIRTH STATE		675. BIRTH CITY		676. BIRTH COUNTY		677. BIRTH DISTRICT		678. BIRTH TOWNSHIP		679. BIRTH VILLAGE		680. BIRTH CENSUS TRACT		681. BIRTH BLOCK		682. BIRTH HOUSE NUMBER		683. BIRTH STREET		684. BIRTH CITY		685. BIRTH COUNTY		686. BIRTH STATE		687. BIRTH COUNTRY		688. BIRTH DATE		689. BIRTH TIME		690. BIRTH PLACE		691. BIRTH COUNTRY		692. BIRTH STATE		693. BIRTH CITY		694. BIRTH COUNTY		695. BIRTH DISTRICT		696. BIRTH TOWNSHIP		697. BIRTH VILLAGE		698. BIRTH CENSUS TRACT		699. BIRTH BLOCK		700. BIRTH HOUSE NUMBER		701. BIRTH STREET		702. BIRTH CITY		703. BIRTH COUNTY		704. BIRTH STATE		705. BIRTH COUNTRY		706. BIRTH DATE		707. BIRTH TIME		708. BIRTH PLACE		709. BIRTH COUNTRY		710. BIRTH STATE		711. BIRTH CITY		712. BIRTH COUNTY		713. BIRTH DISTRICT		714. BIRTH TOWNSHIP		715. BIRTH VILLAGE		716. BIRTH CENSUS TRACT		717. BIRTH BLOCK		718. BIRTH HOUSE NUMBER		719. BIRTH STREET		720. BIRTH CITY		721. BIRTH COUNTY		722. BIRTH STATE		723. BIRTH COUNTRY		724. BIRTH DATE		725. BIRTH TIME		726. BIRTH PLACE		727. BIRTH COUNTRY		728. BIRTH STATE		729. BIRTH CITY		730. BIRTH COUNTY		731. BIRTH DISTRICT		732. BIRTH TOWNSHIP		733. BIRTH VILLAGE		734. BIRTH CENSUS TRACT		735. BIRTH BLOCK		736. BIRTH HOUSE NUMBER		737. BIRTH STREET		738. BIRTH CITY		739. BIRTH COUNTY		740. BIRTH STATE		741. BIRTH COUNTRY		742. BIRTH DATE		743. BIRTH TIME		744. BIRTH PLACE		745. BIRTH COUNTRY		746. BIRTH STATE		747. BIRTH CITY		748. BIRTH COUNTY		749. BIRTH DISTRICT		750. BIRTH TOWNSHIP		751. BIRTH VILLAGE		752. BIRTH CENSUS TRACT		753. BIRTH BLOCK		754. BIRTH HOUSE NUMBER		755. BIRTH STREET		756. BIRTH CITY		757. BIRTH COUNTY		758. BIRTH STATE		759. BIRTH COUNTRY		760. BIRTH DATE		761. BIRTH TIME		762. BIRTH PLACE		763. BIRTH COUNTRY		764. BIRTH STATE		765. BIRTH CITY		766. BIRTH COUNTY		767. BIRTH DISTRICT		768. BIRTH TOWNSHIP		769. BIRTH VILLAGE		770. BIRTH CENSUS TRACT		771. BIRTH BLOCK		772. BIRTH HOUSE NUMBER		773. BIRTH STREET		774. BIRTH CITY		775. BIRTH COUNTY		776. BIRTH STATE		777. BIRTH COUNTRY		778. BIRTH DATE		779. BIRTH TIME		780. BIRTH PLACE		781. BIRTH COUNTRY		782. BIRTH STATE		783. BIRTH CITY		784. BIRTH COUNTY		785. BIRTH DISTRICT		786. BIRTH TOWNSHIP		787. BIRTH VILLAGE		788	
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3163

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berrett</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			
c. LENGTH OF STAY IN 1b <u>8 mos.</u>				d. STREET ADDRESS <u>Oakland Road</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>90 Singer Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>-</u> Last <u>VAUGHN</u>				4. DATE OF DEATH Month <u>March</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 6, 1888</u> 70 yrs.	
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life) even if retired <u>Spinner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Woolen Mills</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Samuel Vaughn</u>				14. MOTHER'S MAIDEN NAME <u>Linda Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. Oliver Fairbanks - Sykesville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>722.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crippling Rheumatoid Arthritis</u> DUE TO (c) <u>Coronary and arterio-sclerosis</u> INTERVAL BETWEEN ONSET OF DEATH <u>3 days</u> <u>30 years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 9, 1957</u> , to <u>March 2, 1958</u> , that I last saw the deceased alive on <u>March 1, 1958</u> , and that death occurred at <u>7:19 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>37 Central Avenue</u> DATE SIGNED <u>3-2-58</u>							
ACTUAL SIGNATURE <u>Bertrand R. Gau</u> M.D. <u>37 Central Avenue</u>				PHYSICIAN'S NAME (Type) <u>Bertrand R. GAU</u> <u>SYKESVILLE Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>3-5-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakland</u>		22d. LOCATION (City, town, or county) (State) <u>Sykesville - Carroll Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Knight</u> ADDRESS <u>Sykesville, Md.</u>				24a. REC'D BY REGISTRAR <u>MAH 4</u> DATE <u>3-2-58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Dech</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1958

RECEIVED

3164

CERTIFICATE OF DEATH

Reg. Dist. No. 03146

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Henryton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 52 days		d. STREET ADDRESS 1641 Ruxton Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Henryton State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Betty Middle Venable Last Venable		4. DATE OF DEATH Month March Day 22 Year 1958	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February, 1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Roanoke, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Grace Taylor		Address 1641 Ruxton Avenue - 16	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Insufficiency DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Far advanced Bilateral Pulmonary TB DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from January 29, 1958 , to March 22, 1958 , that I last saw the deceased alive on March 22, 1958 , and that death occurred at 11:15 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE E. M. Maculans, M.D.		ADDRESS (Street, city or town, state) Henryton, Maryland DATE SIGNED 3-22-58	
PHYSICIAN'S NAME (Type) E. M. Maculans, M.D., Supt. Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	3-25-58	Not Cal.	Brooklyn, D.C.
23. FUNERAL DIRECTOR'S SIGNATURE E. A. Wilson		24a. REC'D BY REGISTRAR 1000 Brantyan	
ADDRESS		24b. REGISTRAR'S SIGNATURE W. Beach	
DATE MAR 26 '58			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

ROBERT A. S.

MAR 25 1968 -

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Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3165

CERTIFICATE OF DEATH

Reg. Dist. No.

03147

1. PLACE OF DEATH a. COUNTY CARROLL CO. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL CO.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER	
c. LENGTH OF STAY IN 1b 6 1/2 yrs.		d. STREET ADDRESS 1312 STONER AVE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 312 STONER AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE GATENBY WARD		4. DATE OF DEATH Month Day Year MARCH 31 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 9, 1876
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) LEEDS, ENGLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN GAWTHORPE		14. MOTHER'S MAIDEN NAME ANNIE ELIZA MOUNTAIN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. MR. SIDNEY J. WARD, WESTMINSTER, MD.	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Renal Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) C Myocardial degeneration DUE TO (c) + decompensation	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1951	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from October 20, 1957 to March 31, 1958 , that I last saw the deceased alive on February 26, 1958 , and that death occurred at 10:15 P.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE W. E. Speicher M.D. Westminster Md		DATE SIGNED 4/1/58	
PHYSICIAN'S NAME (Type)		22a. BIRTH, CREMATION, REMOVAL (Specify) CREMATION	
22b. DATE THEREOF APRIL 3, 1958		22c. NAME OF CEMETERY OR CREMATORY LOUDON PARK CEM. Co.	
22d. LOCATION (City, town, or county) (State) BALTIMORE Md.		23. FUNERAL DIRECTOR'S SIGNATURE J. E. Meyer, Jr. Westminster, Md.	
24a. REC'D BY REGISTRAR APR 3 '58		24b. REGISTRAR'S SIGNATURE W. E. Speicher	

BUREAU - V. S.

APR 7 1959

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. **03148**

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TANEY TOWN c. LENGTH OF STAY IN 1b YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FREDERICK ST.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TANEY TOWN d. STREET ADDRESS FREDERICK ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FLORA Middle ETTA Last WELCH		4. DATE OF DEATH Month MAR Day 4 Year 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR 25 - 1893
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 0 Days 4 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN W STONEMAN		14. MOTHER'S MAIDEN NAME LEONA GARDNER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214-28-5739	
17. INFORMANT MAHLON WELCH		Address UNION BRIDGE MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic C-V disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) INTERVAL BETWEEN ONSET AND DEATH years.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) JAMES T. MARSH		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3/4/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR 6 - 1958	
22c. NAME OF CEMETERY OR CREMATORY HAUGHS		22d. LOCATION (City, town, or county) (State) FREDERICK CO. MD	
23. FUNERAL DIRECTOR'S SIGNATURE DR Hartzler		ADDRESS Union Bridge, Md	
24a. RECEIVED BY REGISTRAR MAR 10 58		DATE DATE	
24b. REGISTRAR'S SIGNATURE W. H. Beach			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAR 10 1953

BUREAU V. S.

MARY AND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

DECEASED
NAME
AGE
SEX
RACE
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
MANNER OF DEATH
SIGNATURE OF EXAMINER
DATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3167

CERTIFICATE OF DEATH

Reg. Dist. No.

03149

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy	
		d. STREET ADDRESS Twin Arch Rd.	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle W. Last WETZEL		4. DATE OF DEATH Month MARCH Day 14 Year 19 58	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-26-1875
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 14 Days 14 Hours 19 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Thomas Wetzel	
14. MOTHER'S MAIDEN NAME Mary Elizabeth Dayhoff		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. 219-01-9638		17. INFORMANT Mrs. Merwin Moxley, Mt. Airy, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of stomach 151x DUE TO with General Metastasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 151x DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. 11. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 7 , 19 58 , to March 14 , 19 58 , that I last saw the deceased alive on March 14 , 19 58 , and that death occurred at 9:30 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE C. M. Waltz		DATE SIGNED 3-16-58	
PHYSICIAN'S NAME (Type) C. M. Waltz		M.D. M. Moxley	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-17-1958	
22c. NAME OF CEMETERY Bethany		22d. LOCATION (City, town, or county) (State) Carroll Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		ADDRESS Winfield, Maryland	
24a. REC'D BY REGISTRAR DATE MAR 18 '58		24b. REGISTRAR'S SIGNATURE W. H. Beach	

MAR 18 1953

RECEIVED

3168
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll Md</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Long View Nursing Home</u>		d. STREET ADDRESS <u>214 York St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type of print) <u>Minnie</u> First <u>Wink</u> Middle <u>Wink</u> Last <u>Wink</u>		4. DATE OF DEATH <u>Mar 28</u> 19 <u>58</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/31/1879</u>
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John E. Heese</u>		14. MOTHER'S MAIDEN NAME <u>Margaretta Kitzenthaler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Howard Wink Manchester Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>334 X</u> DUE TO <u>antemortem cerebral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>antemortem (generalized)</u> DUE TO (c) <u>5 yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>F fractured hip - Jan 3 - 58</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1948</u> , to <u>Mar 28 1958</u> , that I last saw the deceased alive on <u>3/27</u> , 19 <u>58</u> , and that death occurred at <u>3 A</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>23 N. Main St</u> DATE SIGNED <u>3/29/58</u>	
ACTUAL SIGNATURE <u>W H Foard</u> M.D.			
PHYSICIAN'S NAME (Type) <u>W. H Foard M.D</u> <u>Manchester, Md</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify)	22b. DATE THEREOF <u>3/31/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Manchester Md</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Fredrick Bucher Hanover</u> ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE <u>Arthur</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

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CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. DATE OF BIRTH		6. DATE OF DEATH	
7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH	
10. SIGNATURE OF PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF WITNESS		15. SIGNATURE OF WITNESS	
16. SIGNATURE OF WITNESS		17. SIGNATURE OF WITNESS		18. SIGNATURE OF WITNESS	
19. SIGNATURE OF WITNESS		20. SIGNATURE OF WITNESS		21. SIGNATURE OF WITNESS	
22. SIGNATURE OF WITNESS		23. SIGNATURE OF WITNESS		24. SIGNATURE OF WITNESS	
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BUREAU V. S.

APR 3 1953

RECEIVED

3169

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b 2mos. 12days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				3v01.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Springfield State Hospital				d. STREET ADDRESS 1631 E. 32nd St. #18			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First GEORGE Middle H. Last WINTERLING				4. DATE OF DEATH Month March Day 1 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1885	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - Retired		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Winterling				14. MOTHER'S MAIDEN NAME Elizabeth Vogler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-03-8760		17. INFORMANT Address Springfield Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Cancer of sigmoid with cholestomy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C.B.S. assoc. with senile brain disease, with psychotic reaction. Diabetes Mellitus. 260x						INTERVAL BETWEEN ONSET AND DEATH Years Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from December 19, 1957 to March 1, 1958 , that I last saw the deceased alive on February 28, 1958 , and that death occurred at 6:35A M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Springfield State Hospital DATE SIGNED 3/1/58							
ACTUAL SIGNATURE Edmund Lusthaus		PHYSICIAN'S NAME (Type) Edmund Lusthaus, M.D. Sykesville, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/4/58		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Hickner & Sons Balto - 17, Md.				24a. REC'D BY REGISTRAR DATE MAR 4 1958		24b. REGISTRAR'S SIGNATURE W. J. Hickner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED [Illegible]		2. PLACE OF BIRTH [Illegible]	
3. SEX [Illegible]		4. AGE [Illegible]	
5. OCCUPATION [Illegible]		6. MARITAL STATUS [Illegible]	
7. DATE OF DEATH [Illegible]		8. TIME OF DEATH [Illegible]	
9. CAUSE OF DEATH [Illegible]		10. PLACE OF DEATH [Illegible]	
11. SIGNATURE OF PHYSICIAN [Illegible]		12. SIGNATURE OF REGISTRAR [Illegible]	
13. SIGNATURE OF WITNESS [Illegible]		14. SIGNATURE OF WITNESS [Illegible]	
15. SIGNATURE OF WITNESS [Illegible]		16. SIGNATURE OF WITNESS [Illegible]	
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97. SIGNATURE OF WITNESS [Illegible]		98. SIGNATURE OF WITNESS [Illegible]	
99. SIGNATURE OF WITNESS [Illegible]		100. SIGNATURE OF WITNESS [Illegible]	

RECEIVED
MAR 4 1959
BUREAU V. S.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3170

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 4 yrs. 1 mon, 7 days Baltimore 3 V 01 - 4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 420 S. Regester St.	
3. NAME OF DECEASED (Type or print) Kazimer WISNESKY		4. DATE OF DEATH Month March Day 18 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown
9. AGE (In years last birthday) 64 ? yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Soldier		10b. KIND OF BUSINESS OR INDUSTRY Army	
11. BIRTHPLACE (State or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? Poland	
13. FATHER'S NAME John Wisniewski		14. MOTHER'S MAIDEN NAME Anna Niedzwiecki	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes NW 1		16. SOCIAL SECURITY NO. None	
17. INFORMANT SISTER MARYANNA GLENNOWIECKI		420 S. Regester St Springfield State Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) Schizophrenic reaction, paranoid type. DUE TO cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
INTERVAL BETWEEN ONSET AND DEATH Minutes			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. None 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE James T. Marsh		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) James T. Marsh, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/22/58	
22c. NAME OF CEMETERY OR CREMATORY Holy Rosary		22d. LOCATION (City, town, or county) (State) Balto. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. S. Fialkowski		24. REGISTERED BY REGISTER DATE	

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

18

RECEIVED
MAR 21 1959
BUREAU V. 2

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3171

CERTIFICATE OF DEATH

Reg. Dist. No. 03153

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LOCUST ST</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>ELIZABETH</u> Last <u>YINGLING</u>				4. DATE OF DEATH Month <u>MAR</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 12 - 1875</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>LEVI ROWE</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN ENGLAR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-34-4429A</u>		17. INFORMANT <u>HARRY YINGLING</u> Address <u>UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular</u> DUE TO <u>arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. <u>11</u> p. m. Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 6, 1958</u> , to <u>MAR 13, 1958</u> , that I last saw the deceased alive on <u>MAR 13, 1958</u> , and that death occurred at <u>11:31 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>T. N. Legg</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge MD</u>			
PHYSICIAN'S NAME (Type) <u>T. N. LEGG MD</u>				DATE SIGNED <u>3-13-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR 16 - 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LUTHERAN</u>		22d. LOCATION (City, town, or county) (State) <u>UNION TOWN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ed Hartzler & Sons Union Bridge Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 17 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. ...</u>	

BUREAU V. S.

MAR 17 1953

RECEIVED

3102

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>765 CHURCH ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLARANCE</u> Middle <u>WAMPLER</u> Last <u>ZEPP</u>				4. DATE OF DEATH Month <u>MARCH</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 30, 1874</u>	9. AGE (In years last birthday) <u>83</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LAWRENCE ZEPP</u>				14. MOTHER'S MAIDEN NAME <u>REBECCA WAMPLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>ALVIN T. ZEPP WESTMINSTER, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CONGESTIVE HEART FAILURE</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>10 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>MARCH 1, 1958</u> to <u>MARCH 22, 1958</u> , that I last saw the deceased alive on <u>MARCH 22, 1958</u> , and that death occurred at <u>P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>19 N. CHURCH ST</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Daniel J Welles</u> PHYSICIAN'S NAME (Type) <u>WESTMINSTER, MARYLAND</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3-26-1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David L. Bankard Westminister, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. L. Couch</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUCKLEY V. S.

MAR 26 1953

RECEIVED